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**State:** District of Columbia **First Filing Company:** Capitol Indemnity Corporation, ...  
**TOI/Sub-TOI:** 23.0 Fidelity/23.0000 Fidelity  
**Product Name:** Fidelity Application & Bond Form Revision  
**Project Name/Number:** Fidelity Application & Bond Form Revision/18-FID-FO-CW-044

## Filing at a Glance

Companies: Capitol Indemnity Corporation  
Platte River Insurance Company

Product Name: Fidelity Application & Bond Form Revision

State: District of Columbia

TOI: 23.0 Fidelity

Sub-TOI: 23.0000 Fidelity

Filing Type: Form

Date Submitted: 05/03/2018

SERFF Tr Num: CAPC-131485299

SERFF Status: Assigned

State Tr Num:

State Status:

Co Tr Num: 18-FID-FO-CW-044

Effective Date: 06/15/2018

Requested (New):

Effective Date: 06/15/2018

Requested (Renewal):

Author(s): Stephanie Pasker

Reviewer(s): Carmen Belen (primary)

Disposition Date:

Disposition Status:

Effective Date (New):

Effective Date (Renewal):

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**First Filing Company:** Capitol Indemnity Corporation, ...

## General Information

Project Name: Fidelity Application & Bond Form Revision  
Project Number: 18-FID-FO-CW-044  
Reference Organization:  
Reference Title:  
Filing Status Changed: 05/04/2018  
State Status Changed:  
Created By: Stephanie Pasker  
Corresponding Filing Tracking Number:

Status of Filing in Domicile:  
Domicile Status Comments:  
Reference Number:  
Advisory Org. Circular:  
  
Deemer Date:  
Submitted By: Stephanie Pasker

### Filing Description:

RE: Fidelity Application & Bond Form Revision  
Company File #: 18-FID-FO-CW-044  
NAIC #: 0501-10472 (CIC), 0501-18619 (PR)  
FEIN #:39-0971527 (CIC), 56-0997453 (PR)

Capitol Indemnity Corporation and Platte River Insurance Company would like to place on file revisions to our Fidelity applications. We have made the following changes:

- Header – includes company logo and company names
- Fraud language – revised to include all states
- Signature section – revised to be consistent between all Fidelity applications

FAP 001-BSB - Business Service Bond Application  
FAP 002-ERISA - ERISA Bond Application  
FAP 003-R - Application for Fidelity Forgery Coverages Comp UW & Rating Survey (Renewal)  
FAP 005 - Application for a Crime Protection Policy For Mercantile Entities  
FAP 006 - Application for a Crime Protection Policy For Public Entities  
FAP 007 - Application for Crime Protection Policy Comprehensive Underwriting & Rating Survey

We would also like to place on file a revision to our Employee Dishonesty Bond form, FBD 002-ERISA based off changes the SFAA made to their form.

FBD 002-ERISA - Employee Dishonesty Bond

Thank you for your time and consideration of this filing.

## Company and Contact

### Filing Contact Information

Stephanie Pasker, Senior Product Analyst spasker@capspecialty.com  
PO Box 5900 608-829-4856 [Phone]  
Madison, WI 53705

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### Filing Company Information

Capitol Indemnity Corporation	CoCode: 10472	State of Domicile: Wisconsin
PO Box 5900	Group Code: 501	Company Type:
Madison, WI 53705	Group Name:	State ID Number:
(608) 829-4200 ext. [Phone]	FEIN Number: 39-0971527	

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Platte River Insurance Company	CoCode: 18619	State of Domicile: Nebraska
PO Box 5900	Group Code: 501	Company Type:
Madison, WI 53705	Group Name:	State ID Number:
(608) 829-4200 ext. [Phone]	FEIN Number: 56-0997453	

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### Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

State: District of Columbia

First Filing Company:

Capitol Indemnity Corporation, ...

TOI/Sub-TOI: 23.0 Fidelity/23.0000 Fidelity

Product Name: Fidelity Application &amp; Bond Form Revision

Project Name/Number: Fidelity Application &amp; Bond Form Revision/18-FID-FO-CW-044

## Form Schedule

Item No.	Schedule Item Status	Form Name	Form Number	Edition Date	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		Business Service Bond Application	FAP 001-BSB	(05-18)	ABE	Replaced	Previous Filing Number:	CAPC-128920743	0.000	FAP 001-BSB (05-18) - Business Service Bond Application.pdf
							Replaced Form Number:	FAP 001-BSB (01-13)		
2		ERISA Bond Application	FAP 002-ERISA	(05-18)	ABE	Replaced	Previous Filing Number:	CAPC-128920743	0.000	FAP 002-ERISA (05-18) - ERISA Bond Application.pdf
							Replaced Form Number:	FAP 002-ERISA (01-13)		
3		Application for Fidelity Forgery Coverages Comp UW & Rating Survey (Renewal)	FAP 003-R	(05-18)	ABE	Replaced	Previous Filing Number:	CAPC-128920743	0.000	FAP 003-R (05-18) - Application for Fidelity Forgery Cov Comp UW & Rating Survey (Renewal).pdf
							Replaced Form Number:	FAP 003-R (01-13)		
4		Application for a Crime Protection Policy For Mercantile Entities	FAP 005	(05-18)	ABE	Replaced	Previous Filing Number:	CAPC-129545181	0.000	FAP 005 (05-18) - Application for a Crime Protection Policy For Mercantile Entities.pdf
							Replaced Form Number:	FAP 005-DC (05-14)		
5		Application for a Crime Protection Policy For Public Entities	FAP 006	(05-18)	ABE	Replaced	Previous Filing Number:	CAPC-129288194	0.000	FAP 006 (05-18) - Application for a Crime Protection Policy For Public Entities.pdf
							Replaced Form Number:	FAP 006-DC (12-13)		
6		Application for Crime Protection Policy Comprehensive Underwriting & Rating Survey	FAP 007	(05-18)	ABE	Replaced	Previous Filing Number:	CAPC-129545181	0.000	FAP 007 (05-18) - Application for Crime Protection Policy Comprehensive UW & Rating Survey .pdf
							Replaced Form Number:	FAP 007-DC (05-14)		
7		Employee Dishonesty Bond	FBD 002-ERISA	(05-18)	BND	Replaced	Previous Filing Number:	CAPC-126711757	0.000	FBD 002-ERISA (05-18).pdf
							Replaced Form Number:	FBD 002-ERISA (07-10)		

<b>State:</b>	District of Columbia	<b>First Filing Company:</b>	Capitol Indemnity Corporation, ...
<b>TOI/Sub-TOI:</b>	23.0 Fidelity/23.0000 Fidelity		
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**Form Type Legend:**

<b>ABE</b>	Application/Binder/Enrollment	<b>ADV</b>	Advertising
<b>BND</b>	Bond	<b>CER</b>	Certificate
<b>CNR</b>	Canc/NonRen Notice	<b>DEC</b>	Declarations/Schedule
<b>DSC</b>	Disclosure/Notice	<b>END</b>	Endorsement/Amendment/Conditions
<b>ERS</b>	Election/Rejection/Supplemental Applications	<b>OTH</b>	Other



Surety & Fidelity Bond Department, PO Box 5900, Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## BUSINESS SERVICE BOND APPLICATION

Agency Name:		Agency No.		Bond No.	
Business Name: (Must be exactly as it is to appear on the bond)					
Phone Number:					
Address:	(street)		(city)	(state)	(zip)
Type of Business:					
Amount of Bond \$		Effective Date:		Number of Owners:	
Number of Employees:	Full Time		Part Time		How long have you been in business?
Do you investigate the employment history of job applicants?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If "No", please explain:		
Do you perform criminal history background checks on job applicants?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If "No", please explain:		
Have you had a bond with another surety?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", what is the reason for changing companies? <b>(MO applicants DO NOT answer this question)</b>		
Have you had any prior losses of clients' property?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", please attach details on a separate sheet		

### CONVICTION CLAUSE

In order to protect you and your employees against unjustified allegations of dishonesty, the employee must be tried and convicted of the alleged dishonest act in a court of proper jurisdiction before coverage will apply.

### READ CAREFULLY AND SIGN

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The insured represents that the information furnished in this application and any supplemental application is complete, true and correct. Any misrepresentation, omission, concealment or incorrect statement of a material fact, in the application or otherwise, shall be grounds for the rescission of any coverage issued on reliance upon such information. Be aware that the underwriting company has relied on your answers in accepting, rating and issuing your policy and where applicable in certain jurisdictions, this application becomes part of the policy issued to the insured as an endorsement.

The individuals and/or organizations indicated below hereby agree that any electronic signatures (including facsimile signatures) utilized in connection with the execution of this document shall be considered originals and be fully binding and enforceable. Further, the use of any electronic signature by a party shall be evidence of that party's intent to be bound to the terms of such document. The parties agree that they shall not raise any defense (statutory or otherwise) to the enforceability of this document based upon the fact an electronic signature has been used.

## **FRAUD STATEMENT:**

### **APPLICABLE IN: AL, AR, DC, LA, MD, NM, RI AND WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. \*Applies in MD only.

### **APPLICABLE IN: CO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

### **APPLICABLE IN: FL AND OK**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.

### **APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

### **APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only.

### **APPLICABLE IN: ME, TN, VA AND WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME only.

### **APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

### **APPLICABLE IN: OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

### **APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

\_\_\_\_\_  
(Print Name)

## **SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

## ERISA BOND APPLICATION

Name of Plan(s) (*exact name of Plan(s) to be covered*) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

1. Is the Plan audited annually by a CPA? ☐ YES ☐ NO

If yes, provide name of the CPA firm \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Does an Independent Administrator service the Plan? ☐ YES ☐ NO

If yes, provide name of Administrator \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Please note Independent Administrators will not be covered under Bond unless you contact your Branch Office.*

3. How many trustees are there for the Plan? \_\_\_\_\_

4. Are two signatures required to withdraw from the Plan? ☐ YES ☐ NO (*If no, submit to your Branch Office for underwriting*)

5. Who reconciles Plan's bank statement? \_\_\_\_\_

6. Who deposits funds in Plan's accounts? \_\_\_\_\_

*(If the same name is listed in both questions 5 and 6, submit application to your Branch Office for underwriting)*

Amount of Bond \$ \_\_\_\_\_

**Qualified Plan Assets \$** \_\_\_\_\_ *Bond amount must be for at least 10% of Qualified Plan Assets. Maximum Bond limit is \$500,000.*
**Non-Qualified Plan Assets \$** \_\_\_\_\_ *Bond amount must be for 100% of the Non-Qualified Plan Assets.*

Premium Basis ☐ 1 Year prepaid ☐ 3 Year Prepaid Proposed Effective Date \_\_\_\_\_

Is Inflation Guard Coverage desired? ☐ YES ☐ NO

Please call the Branch Office for Authorization on Bonds over \$100,000.

### READ CAREFULLY AND SIGN

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The individuals and/or organizations indicated below hereby agree that any electronic signatures (including facsimile signatures) utilized in connection with the execution of this document shall be considered originals and be fully binding and enforceable. Further, the use of any electronic signature by a party shall be evidence of that party's intent to be bound to the terms of such document. The parties agree that they shall not raise any defense (statutory or otherwise) to the enforceability of this document based upon the fact an electronic signature has been used.



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**APPLICABLE IN: CO**

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**APPLICABLE IN: FL AND OK**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.

**APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only.

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**APPLICABLE IN: NJ**

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**APPLICABLE IN: OR**

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**APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_



Surety & Fidelity Bond Department, PO Box 5900, Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## APPLICATION FOR FIDELITY/FORGERY COVERAGES COMPREHENSIVE UNDERWRITING & RATING SURVEY (RENEWAL)

### NAMED INSURED:

If ERISA Coverage is needed provide the plan name

### INSURED'S ADDRESS:

Are you a **Proprietorship** ☐ **Partnership** ☐ **Corporation** ☐

1. Type of Business: \_\_\_\_\_
2. Date Established: \_\_\_\_\_
3. What is the total number of Employees? \_\_\_\_\_ Total number of Officers? \_\_\_\_\_  
How many employees regularly handle money, securities, or inventory? \_\_\_\_\_  
How many locations? \_\_\_\_\_ List other locations on reverse side and advise operation.
4. Amount of EMPLOYEE DISHONESTY COVERAGE Desired? \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_
5. Amount of FORGERY COVERAGE Desired? \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_
6. Effective date of coverage requested, *if this application is approved?* \_\_\_\_\_
7. Coverage is Primary ☐ Coverage is excess over company/policy # \_\_\_\_\_

### INTERNAL CONTROLS:

8. Is an audit performed each year? YES ☐ NO ☐ Prepared by CPA ☐ INHOUSE ☐  
*If CPA prepared, Is it an Audit* ☐ *Review* ☐ *Compilation* ☐
9. Are bank accounts reconciled by someone not authorized to deposit or withdraw therefrom? YES ☐ NO ☐
10. How Often? \_\_\_\_\_
11. Will all checks issued by the Insured be countersigned? YES ☐ NO ☐  
If no, who signs (advise name and position) \_\_\_\_\_

### PRESENT COVERAGE:

12. List all fidelity, and forgery coverages now carried: Check if none ☐  

Coverage	Limit of Liability	Name of Insurer	Policy Number

### LOSS EXPERIENCE:

13. List all employee dishonesty losses in the last three (3) years, itemizing each loss separately:  
Check if none ☐  

Date of Loss	Amount	Description	Precautions Taken to Prevent Repetition

### READ CAREFULLY AND SIGN

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgement of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

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Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

## APPLICATION FOR A CRIME PROTECTION POLICY FOR MERCANTILE ENTITIES

Named Insured: \_\_\_\_\_  
(Please list all insured's, including Employee Benefit Plans)

Principal Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Policy Coverage offered: Crime Protection Policy for Mercantile Entities, **Loss Sustained Form**

Primary, excess, contributing with: \_\_\_\_\_

### INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES

INSURING AGREEMENT	<u>Limit of Insurance</u>	<u>Deductible Amount</u>
1. Employee Dishonesty	\$	\$
2. Forgery or Alteration	\$	\$
3. Inside the Premises	\$	\$
4. Outside the Premises	\$	\$
5. Computer Fraud	\$	\$
6. Money Orders and Counterfeit Paper Currency	\$	\$
Insuring Agreements added by Endorsement:		
7. Loss of Clients' Property (SE 00 48, FEN 004)	\$	\$
8. Funds Transfer Fraud (SE 00 41)	\$	\$
9. Fraudulently Induced Transfers (SE 01 67)	\$	\$
10. ERISA Dishonesty Coverage (SE 01 71)	\$	\$

To become effective or to be continued as of 12:01 a.m. on \_\_\_\_\_ to 12:01 a.m. on \_\_\_\_\_

**Premium is payable: Annually**

#### 1. DESCRIPTION OF YOUR ORGANIZATION

- (a) Type of business (check appropriate box):  
Proprietorship ☐ Partnership ☐ Corporation ☐ Other ☐ If other, explain \_\_\_\_\_
- (b) Date your business was established: \_\_\_\_\_
- (c) Classify your predominant activity: (Check box below)  
☐ Manufacturer ☐ Processor ☐ Wholesaler ☐ Distributor ☐ Retailer ☐ Servicer ☐ Other
- (d) Describe the products or services of your predominant business or activity: \_\_\_\_\_
- (e) Has there been any change in ownership or management within the past three years? ☐ Yes ☐ No  
If "Yes", explain \_\_\_\_\_

#### 2. RATING DATA FOR INSURING AGREEMENTS

##### Insuring Agreements 1, 2 and 5

Classification of Employees: #of Officers \_\_\_\_\_ # of Employees \_\_\_\_\_

##### Insuring Agreement 7

List the number of employees who handle, have custody of, maintain records of or have access to money, securities or other property owned by **your clients**. \_\_\_\_\_

##### Insuring Agreements 3 and 4

- (a) Indicate the number of locations \_\_\_\_\_
- (b) Indicate the number of outside messengers \_\_\_\_\_
- (c) Do guards accompany each messenger? Yes ☐ No ☐
- (d) Are your premises secured by watchpersons? Yes ☐ No ☐
- (e) Are your premises secured by an alarm system? Yes ☐ No ☐
- Please provide details: \_\_\_\_\_

- (f) Is a safe used at all locations? Yes ☐ No ☐  
Please provide details: \_\_\_\_\_
- (g) What other measures have been taken to provide physical protection (private conveyance, messenger bags, safe alarms, Armored Car, etc.)? \_\_\_\_\_

### 3. AUDIT PROCEDURES

- (a) Is there an audit by a CPA, public accountant, independent of your organization? ☐ Yes ☐ No  
If "Yes", how often (check the appropriate box): ☐ Quarterly ☐ Semi-Annually ☐ Annually
- (b) Name and address of person performing audit: \_\_\_\_\_
- (c) Are all locations audited? ☐ Yes ☐ No
- (d) Is the audit in compliance with generally accepted auditing standards and so certified? ☐ Yes ☐ No  
If "No", indicate the scope of services (check the appropriate box): ☐ Review ☐ Compilation  
☐ Other, Explain \_\_\_\_\_
- (e) Is the report rendered directly to the Owner, Partners or Directors? ☐ Yes ☐ No
- (f) Date of completion of last audit of: Cash and Accounts \_\_\_\_\_ Inventory \_\_\_\_\_
- (g) Were any discrepancies or loose practices commented upon in the audit? ☐ Yes ☐ No  
If "Yes", submit a copy of the auditor's comments.
- (h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a Certified Public Accountant or equivalent? ☐ Yes ☐ No  
If "Yes", are the reports rendered directly to the Owner, Partners or Directors? ☐ Yes ☐ No
- \* If coverage desired is at \$250,000 please submit a copy of the annual financial report**

### 4. INTERNAL CONTROLS

- (a) Are bank accounts reconciled monthly? ☐ Yes ☐ No
- (b) Are bank accounts reconciled by someone not authorized to deposit or withdraw? ☐ Yes ☐ No  
If "No", explain \_\_\_\_\_
- (c) Is countersignature of all checks required? ☐ Yes ☐ No  
Above what amount? \$ \_\_\_\_\_
- (d) Do you have (use) funds transfer transactions (i.e. Wire Transfers, ACH, EFT, etc.)? ☐ Yes ☐ No  
If "Yes", How often are funds transfer transactions reconciled? \_\_\_\_\_  
Are they reconciled by someone not authorized to approve, initiate or handle them? ☐ Yes ☐ No
- (e) Does supporting documentation accompany all checks to be signed? ☐ Yes ☐ No  
If "No", explain \_\_\_\_\_
- (f) Do you maintain a list of approved vendors? ☐ Yes ☐ No
- (g) Are securities subject to the joint control of two or more employees? ☐ Yes ☐ No
- (h) Are your employees required to take at least 1 or 2 consecutive weeks of vacation? ☐ Yes ☐ No
- (i) Explain screening procedures for new employees: \_\_\_\_\_

### 5. PRIOR INSURANCE

- (a) Has any similar insurance been declined or canceled during the past three years? **(MO applicants DO NOT answer this question)** ☐ Yes ☐ No

If "Yes", explain: \_\_\_\_\_

- (b) Prior insurance to be superseded \_\_\_\_\_ Check here if none ☐

Policy Number	Discovery or Loss Sustained	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company

### 6. PRIOR LOSSES

- (a) List below all losses sustained during the past three years that were caused by a loss that would have been covered by an Insuring Agreement you are now applying for. Please list all losses, whether reimbursed or not.

Check here if none ☐

Date of Loss	Type of loss	Amount Recovered From Insurance	Amount Recovered from Other than Insurance	Amount of Loss Pending	Location of Loss

**\* If more than 2 losses, please attach a separate sheet with full details as outlined above.**

## 7. GENERAL INFORMATION

Business Hours	Average # of Employees on Duty	Frequency of Deposits	Night Depository Used?	Annual Gross Sales or Receipts for Last fiscal year.	Other Information

## 8. COVERAGE AMENDMENTS

### (a) Insuring Agreement 1

If insurance is desired on any of your appointed **Agents**, whether they be persons, partnerships or corporations performing any act or service in connection with the ordinary conduct of your business, complete the following:

Names, Addresses of each Agent:

Type of Service  
provided:

Limit of Insurance

\_\_\_\_\_

\$ \_\_\_\_\_  
\$ \_\_\_\_\_

### (b) Insuring Agreement 2

If insurance is desired, complete the following:

No. of Cardholders:

Limit of Insurance:

#### (1) Credit, Debit or Charge Card Instruments:

Covered Instruments (check the appropriate box):

include ☐ or are limited to ☐ Credit, debit or charge cards

Issued to you or any employee for business purposes

\_\_\_\_\_ \$ \_\_\_\_\_

#### (2) Personal Accounts of your officers or partners:

Name(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_

### (c) Insuring Agreements 3 and 4

Increased or Reduced Limits

Limit of Insurance

Specified Period

#### (a) If an increased limit is desired for a specified period, indicate:

Insuring Agreement 3 (*Inside the Premises*)

\$ \_\_\_\_\_

Insuring Agreement 4 (*Outside the Premises*)

\$ \_\_\_\_\_

#### (b) If a decreased limit is desired while the business is closed

and a custodian is not on duty, indicate Overnight Limit

\$ \_\_\_\_\_

#### (c) If a reduced limit is desired for designated premises, messengers or armored motor vehicle companies, complete the following:

Address of Premises	Names of Messengers	Names of Armored Motor Vehicle Companies	Limit of Insurance

## READ CAREFULLY AND SIGN

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

**FRAUD STATEMENT:****APPLICABLE IN: AL, AR, DC, LA, MD, NM, RI AND WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. \*Applies in MD only.

**APPLICABLE IN: CO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**APPLICABLE IN: FL AND OK**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.

**APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only.

**APPLICABLE IN: ME, TN, VA AND WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME only.

**APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICABLE IN: OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_



Surety & Fidelity Bond Department, PO Box 5900, Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## APPLICATION FOR A CRIME PROTECTION POLICY FOR PUBLIC ENTITIES

Named Insured: \_\_\_\_\_

Principal Address: \_\_\_\_\_

Policy Coverage offered: Crime Protection Policy for Public Entities, **Loss Sustained form**

This policy will be Primary ☐ Excess ☐ If EXCESS, enter Primary Policy # and carrier:

### INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES

#### INSURING AGREEMENTS

	<u>Limit of Insurance</u>	<u>Deductible Amount</u>
1. Employee Dishonesty	\$	\$
Per Employee (Up to \$25,000)	\$	\$
2. Forgery or Alteration	\$	\$
3. Inside the Premises	\$	\$
4. Outside the Premises	\$	\$
5. Computer Fraud	\$	\$
6. Money Orders and Counterfeit Paper Currency	\$	\$
Insuring Agreements added by Endorsement		
7. Loss of Clients' Property (SE 00 48, FEN 004)	\$	\$
8. Funds Transfer Fraud (SE 00 41)	\$	\$
9. Fraudulently Induced Transfers (SE 01 67)	\$	\$
10. ERISA Dishonesty Coverage (SE 01 71)	\$	\$

To become effective or to be continued as of 12:01 a.m. on \_\_\_\_\_ to 12:01 a.m. on \_\_\_\_\_

**Premium is payable: Annually**

If this insurance indemnifies an Obligor other than the Named Insured, list below the Obligor name and address:

#### 1. DESCRIPTION OF YOUR ORGANIZATION:

- (a) Is your organization a part of the government of the (check the appropriate box): State ☐, County ☐, City ☐, Town ☐  
Township ☐, Village ☐, Borough ☐, Other Political Subdivision ☐ \_\_\_\_\_
- (b) Is insurance being provided for a School System? ..... Yes ☐ No ☐

#### 2. RATING DATA FOR COVERAGE FORMS 1, 2, 5 AND 7

**Note: Persons required by law to be individually bonded and treasurers or tax collectors by whatever title known, are excluded from coverage under Insuring Agreement 1.**

- (a) Classification of Employees: Enter the number total number of all your employees (excluding those that are required by law to be individually bonded): \_\_\_\_\_
- (b) If Faithful Performance of Duty Coverage is desired, enter the number of your Patrolmen/Women: \_\_\_\_\_
- (c) If Agreement 7 is desired, please provide the number of employees who handle, have custody of, maintain records of, or have access to, money, securities or other property owned by your clients. \_\_\_\_\_

#### 3. RATING DATA FOR INSURING AGREEMENTS 3 AND 4

- (a) Indicate the number of locations \_\_\_\_\_
- (b) Indicate the number of outside messengers \_\_\_\_\_
- (c) Do guards accompany each messenger? Yes ☐ No ☐
- (d) Are your premises secured by watchpersons? Yes ☐ No ☐
- (e) Are your premises secured by an alarm system? Yes ☐ No ☐ If Yes, provide details \_\_\_\_\_
- (f) Is a safe used at all locations? Yes ☐ No ☐ If yes, provide details \_\_\_\_\_
- (g) What other measures have been taken to provide physical protection (private conveyance, messenger bags, safe alarms, etc.)? \_\_\_\_\_



**4. AUDIT PROCEDURES:**

- (a) Is there an audit by a CPA, public accountant or equivalent, independent of your organization?

Yes ☐ No ☐

If "Yes," how often (check the appropriate box): Quarterly ☐, Semi-Annually ☐, Annually ☐

- (b) Name and Address of person or firm performing audit \_\_\_\_\_

- (c) Are all locations audited? ..... Yes ☐ No ☐

- (d) Is the audit made in accordance with generally accepted auditing standards and so certified? Yes ☐ No ☐

If "No," explain the scope of the audit \_\_\_\_\_

- (e) Is the audit report rendered to a regulatory authority? ..... Yes ☐ No ☐

If "Yes," to whom are the reports rendered? \_\_\_\_\_

- (f) Date of completion of last audit \_\_\_\_\_

- (g) Were any discrepancies or internal control weaknesses commented upon in the audit? ..... Yes ☐ No ☐

If "Yes," submit a copy of the audit and auditor's comments.

- (h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a public accountant or equivalent? ..... Yes ☐ No ☐

If "Yes," to whom are the reports rendered? \_\_\_\_\_

**5. INTERNAL CONTROLS (OTHER THAN AUDIT PROCEDURES):**

- (a) Are bank accounts reconciled monthly? ..... Yes ☐ No ☐

- (b) Are bank accounts reconciled by someone not authorized to deposit or withdraw? ..... Yes ☐ No ☐

If "No," explain: \_\_\_\_\_

- (c) Is countersignature of checks required? ..... Yes ☐ No ☐

If "No," explain: \_\_\_\_\_

- (d) Does supporting documentation accompany all checks to be signed? ..... Yes ☐ No ☐

If "No," explain: \_\_\_\_\_

- (e) Are securities subject to joint control of two or more responsible employees? ..... Yes ☐ No ☐

If "No," explain: \_\_\_\_\_

- (f) Explain your screening procedures for new employees \_\_\_\_\_

**6. PRIOR INSURANCE:**

- (a) Has any similar insurance been declined or cancelled during the past three years? **(MO applicants DO NOT answer this question)** ..... Yes ☐ No ☐

If "Yes," explain \_\_\_\_\_

- (b) Prior insurance to be superseded ..... Check if none ☐

Policy Number	Policy form was: Discovery? Loss Sustained?	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company
				\$	

**7. PRIOR LOSSES:**

- (a) List below all losses sustained during the past three years that were caused by: employee dishonesty, forgery, theft of money or securities on or off the premises, computer fraud or counterfeit currency. Please list all losses, whether reimbursed or not.

Check if none ☐

Date of Loss	Type of Loss	Amount of Loss	Amount Recovered from Insurance	Amount Recovered from other than Insurance	Amount of Loss Pending
		\$	\$	\$	\$
		\$	\$	\$	\$

NOTE: If more than 2 losses, please attach a separate sheet describing the loss details.

## 8. COVERAGE AMENDMENTS (ENDORSEMENTS)

### INSURING AGREEMENT 1

(a) Agents Coverage:

If insurance is desired on any of your appointed or elected **Agents**, whether they are persons, partnerships or corporations while performing any act or service in connection with the ordinary function of your organization, complete the following:

<u>Capacity in Which Each Agent Serves:</u>	<u>Limit of Insurance</u>
_____	\$ _____
_____	\$ _____

**\* If more than two agents, attach a separate sheet to provide the details.**

### INSURING AGREEMENT 3 and 4:

(a) Peak Season:

1) If an increased limit is desired for a specified period, indicate:

	<u>Increased Limit</u>	<u>Specified Period (mm/dd/yy)</u>	
	<u>Of Insurance</u>	<u>Start Date:</u>	<u>End Date:</u>
Insuring Agreement 3	\$ _____	_____	_____
Insuring Agreement 4	\$ _____	_____	_____

2) If a decreased limit is desired while the business is closed and a custodian is not on duty, indicate: \$ \_\_\_\_\_

(b) Schedule Coverage

If schedule coverage is desired, complete the following: **(or attach a sheet to list more locations):**

Address of Premises	Insuring Agreement 3 Limit of Insurance	Insuring Agreement 4 Limit of Insurance	Number of Armored Motor Vehicles	Number of Messengers

The present officials/officers and employees of the Insured, in the positions held, as shown herein, have, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information which in the judgment of the Insured indicated that any of the said officials/officers or employees are dishonest. Such knowledge that any official or officer signing for the Insured may now have in respect to his or her own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

### FRAUD STATEMENT:

#### APPLICABLE IN: AL, AR, DC, LA, MD, NM, RI AND WV

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

\*Applies in MD only.

#### APPLICABLE IN: CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

#### APPLICABLE IN: FL AND OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.

**APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only.

**APPLICABLE IN: ME, TN, VA AND WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME only.

**APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICABLE IN: OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and s subject to penalties under state law.

Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_



Surety & Fidelity Bond Department, PO Box 5900, Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## APPLICATION FOR CRIME PROTECTION POLICY COMPREHENSIVE UNDERWRITING & RATING SURVEY

Named Insured: \_\_\_\_\_

Principal Address: \_\_\_\_\_

Policy Coverage offered: Crime Protection Policy for Public Entities, **Loss Sustained form**

This policy will be Primary ☐ Excess ☐ If EXCESS, enter Primary Policy # and carrier: \_\_\_\_\_

### 1. OPERATIONS:

**Public Entities:** Are you a: State ☐ County ☐ City/Town ☐ Other Political Subdivision ☐

**Mercantile Entities:** Are you a: Corporation ☐ Partnership ☐ Individual ☐

1. Type of Operation/Business Description: \_\_\_\_\_

2. Date Established: \_\_\_\_\_

### 2. INTERNAL CONTROLS:

1. Is an audit performed each year? YES ☐ NO ☐

**How Prepared?** In-House ☐ Independent CPA ☐ **Scope?** Audit ☐ Review ☐ Compilation ☐

*If coverage desired is at \$250,000; please submit a copy of the annual financial report.*

2. Are bank accounts reconciled by someone not authorized to deposit or withdraw therefrom? YES ☐ NO ☐

How Often? \_\_\_\_\_

3. Will all checks issued by the insured be countersigned? YES ☐ NO ☐

If no, who signs? (Name and position) \_\_\_\_\_

4. Prior Insurance? YES ☐ NO ☐ Name of carrier if "Yes": \_\_\_\_\_

5. Prior Losses? YES ☐ NO ☐ If Yes, Amount: \$ \_\_\_\_\_ **(attach details of loss)**

6. Do you have (use) funds transfer transactions (i.e. Wire Transfers, ACH, EFT, etc.)? YES ☐ NO ☐

If "Yes", how often are funds transfer transactions reconciled? \_\_\_\_\_

Are they reconciled by someone not authorized to approve, initiate or handle them? YES ☐ NO ☐

7. Does supporting documentation accompany all checks to be signed? YES ☐ NO ☐

If "No", Explain: \_\_\_\_\_

8. Are your employees required to take at least 1 or 2 consecutive weeks of vacation? YES ☐ NO ☐

### 3. INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES:

<u>Insuring Agreement</u>	<u>Limit of Insurance</u>	<u>Deductible Amount</u>
Employee Dishonesty	\$ _____	\$ _____
Forgery or Alteration	\$ _____	\$ _____
Loss of Clients' Property	\$ _____	\$ _____

### 4. RATING DATA:

1. Enter the # of: **Officers/Officials:** \_\_\_\_\_ **Employees, other than Officers/Officials:** \_\_\_\_\_

2. Enter the # of employees that have custody of, or access to, **property of your clients:** \_\_\_\_\_

### 5. For PUBLIC ENTITY Insureds:

**PLEASE NOTE: Persons required by law to be individually bonded and Treasurers and Tax Collectors by whatever title known are excluded from coverage under Employee Dishonesty.**

1. Is Faithful Performance of Duty Coverage desired? YES ☐ NO ☐

If "YES", enter the number of your Patrolmen/women: \_\_\_\_\_

## **READ CAREFULLY AND SIGN**

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgement of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The individuals and/or organizations indicated below hereby agree that any electronic signatures (including facsimile signatures) utilized in connection with the execution of this document shall be considered originals and be fully binding and enforceable. Further, the use of any electronic signature by a party shall be evidence of that party's intent to be bound to the terms of such document. The parties agree that they shall not raise any defense (statutory or otherwise) to the enforceability of this document based upon the fact an electronic signature has been used.

### **FRAUD STATEMENT:**

#### **APPLICABLE IN: AL, AR, DC, LA, MD, NM, RI AND WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

\*Applies in MD only.

#### **APPLICABLE IN: CO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

#### **APPLICABLE IN: FL AND OK**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.

#### **APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

#### **APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only.

#### **APPLICABLE IN: ME, TN, VA AND WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME only.

#### **APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

#### **APPLICABLE IN: OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

#### **APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

<Company Name>

Mailing Address: P.O. Box 5900, Madison, WI 53705-0900

Bond No. \_\_\_\_\_

## EMPLOYEE DISHONESTY BOND

as required by The Employee Retirement Income Security Act of 1974 (ERISA) as amended

### DECLARATIONS

Item 1. Name of Employee Benefit Plans: \_\_\_\_\_  
(HEREIN CALLED THE INSURED)

Principal Address: \_\_\_\_\_  
(NUMBER, STREET)  
\_\_\_\_\_  
(CITY, STATE, ZIP)

Item 1a. Plan Sponsor: \_\_\_\_\_  
(HEREIN CALLED THE INSURED)

Plan Sponsor Address: \_\_\_\_\_  
(NUMBER, STREET)  
\_\_\_\_\_  
(CITY, STATE, ZIP)

Item 2. Bond Period: From 12:01 A.M. on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ to 12:01 A.M. on the effective date of the cancellation or termination of this Bond, standard time at the Principal Address as to each of said dates.

Item 3. Limit of Liability: \_\_\_\_\_ Dollars (\$ \_\_\_\_\_ ).  
(MAXIMUM LIMIT IS \$500,000)

- a. In consideration of the additional premium charged if, at the inception of this policy, you have a Limit of Liability for your Plan that is equal to or greater than that required under ERISA, we agree to automatically increase that Limit of Liability, subject, however, to the Non-Cumulation of Limits in section 9 of the GENERAL CONDITIONS, and subject to a maximum limit of \$500,000. Inflation guard accepted. ☐ YES ☐ NO

Item 4. The liability of the Underwriter is subject to the terms and conditions hereby attached.

Item 5. The Insured by the acceptance of this bond gives notice to the Underwriter terminating or cancelling prior bonds or policy(ies) No.(s). Such termination or cancellation to be effective as of the time this bond becomes effective. To the extent that coverage in this bond replaces coverage in other bonds terminating on the inception date of this bond, coverage under this bond shall not become effective until such other coverage has terminated.

Item 6. In compliance with certain provisions of the Employee Retirement Income Security Act (ERISA):

1. **Covered person** means any natural person who is
  - a. a trustee, officer, employee, administrator or manager, except an administrator or manager who is an independent contractor, of any employee benefit plan(s) insured under this insurance; or
  - b. a director, officer, employee or trustee of the Plan Sponsor, but only while that person is handling money, securities or other property of an employee benefit plan insured under this insurance;

Item 7. If two or more Plans are insured under this insurance, any payment for loss:

- a. Sustained by two or more Plans or
- b. Of commingled funds or other property of two or more Plans that arises out of one "occurrence", is to be shared by each Plan sustaining the loss in the proportion that the amount of insurance required for each Plan under ERISA provision bears to the total of those amounts.

Item 8. **Certain Computer Errors:** loss, or any part thereof, resulting directly from the failure of any computer, computer system or component thereof, embedded chip, microprocessor, or similar electronic device correctly to recognize, interpret or accept a date which is subsequent to December 31, 1999 or accurately to process data or perform any other function because of such a failure. This exclusion applies without regard to ownership of the computer, computer system, chip, microprocessor or similar device; whether or not another cause or event also contributed to the loss; and to the cost of any test, diagnosis, repair, advice, design, or re-programming to discover, guard against or correct such a failure. Provided, however, that this Exclusion shall not apply to any loss or part thereof as to which You can establish coverage under employee dishonesty and the amount of the loss, without reliance upon such a failure.

Cancellation of prior insurance: By acceptance of this policy you give us notice canceling prior policy or bond Nos. \_\_\_\_\_ the cancellation to be effective at the time this policy becomes effective.

SIGNED AND DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_.

Underwriting Service Office Address:  
<Service Office Location>

BY: \_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Print or Type Name of Authorized Representative

*Power of Attorney is not required to execute this bond.*

To be attached to and form a part of an Employee Dishonesty Bond as required by The Employee Retirement Income Security Act of 1974 (ERISA).

#### **INSURING AGREEMENT**

##### **FRAUD OR DISHONESTY**

We will pay for loss of money, securities or other property resulting directly from fraud or dishonesty committed by a covered person.

#### **GENERAL AGREEMENTS**

##### **CONSOLIDATION-MERGER**

- A. If, through consolidation or merger with, or purchase of assets of, some other concern, any person shall become Employees, the Insured shall give the Underwriter written notice thereof and shall pay an additional premium computed pro rata from the date of such consolidation, merger or purchase to the end of the current premium period.

##### **JOINT INSURED**

- B. If more than one Insured is covered under this Bond, the Insured first named shall act for itself and for every other Insured for all purposes of this Bond. Knowledge possessed or discovery made by any Insured or by any partner or officers thereof shall, for the purposes of Section 6, 7 and 12, constitute knowledge possessed or discovery made by every Insured. Cancellation of the insurance hereunder as respects any Employee as provided in Section 12 shall apply to every Insured. If, prior to the cancellation or termination of this Bond in its entirety, this Bond is cancelled or terminated as to any Insured, there shall be no liability for any loss sustained by such Insured unless discovered within one year from the date of such cancellation or termination. The liability of the Underwriter for loss sustained by any or all of the Insured shall not exceed the amount for which the Underwriter would be liable had all such loss been sustained by any one of the Insured. Payment by the Underwriter to the Insured first named of any loss under this Bond shall fully release the Underwriter on account of such loss. If the Insured first named ceases for any reason to be covered under this Bond, then the Insured next named shall thereafter be considered as the Insured first named for all purposes of this Bond.

##### **LOSS UNDER PRIOR BOND OR POLICY**

- C. If the coverage of this Bond is substituted for any prior bond or policy of insurance carried by the Insured or by any predecessor in interest of the Insured, which prior bond or policy is terminated, cancelled or allowed to expire as to the time of such substitution the Underwriter agrees that this Bond applies to loss which is discovered as provided in Section 1 of the Conditions and Limitations and which would have been recoverable by the Insured or such predecessor under such prior bond or policy except for the fact that the time within which to discover loss thereunder has expired; provided:
- (1) the indemnity afforded by this General Agreement C shall be a part of and not in addition to the amount of insurance afforded by this Bond.
  - (2) such loss would have been covered under this Bond had this Bond with its agreements, limitations, and conditions as of the time of such substitution been in force when the acts or defaults causing such loss were committed; and
  - (3) recovery under this Bond on account of such loss shall in no event exceed the amount which would have been recoverable under this Bond in the amount for which it is written as of the time of such substitution, had this Bond been in force when such acts or defaults were committed, or the amount which would have been recoverable under such prior bond or policy had such prior bond or policy continued in force until the discovery of such loss, if the latter amount be smaller.

#### **THE FOREGOING INSURING AGREEMENT AND GENERAL AGREEMENTS ARE SUBJECT TO THE FOLLOWING CONDITIONS AND LIMITATIONS:**

##### **BOND PERIOD, TERRITORY, DISCOVERY**

Section 1. Loss is covered under this Bond only if discovered not later than one year from the end of the Bond Period. This policy covers only acts committed or events occurring within the United States of America.

Subject to General Agreement C, this Bond applies only to loss sustained by the Insured through fraudulent or dishonest acts committed during the Bond Period by any of the Employees engaged in the regular service of the Insured within any of the States of the United States of America, the District of Columbia, Virgin Islands, Puerto Rico, Canal Zone or Canada or while such Employees are elsewhere for a limited period.



## EXCLUSION

Section 2. This Bond does not apply to loss, or to that part of any loss, as the case may be, the proof of which, either as to its factual existence or as to its amount, is dependent upon an inventory computation or a profit and loss computation: provided, however, that this paragraph shall not apply to loss of money or other property which the Insured can prove, through evidence wholly apart from such computations, is sustained by the Insured through any fraudulent or dishonest act or acts committed by any one or more of the Employees. This Bond does not apply to the defense of any legal proceeding brought against the Insured or to fees, costs or expenses incurred or paid by the Insured in prosecuting or defending any legal proceeding whether or not such proceeding results or would result in a loss to the Insured covered by this Bond.

## DEFINITION OF EMPLOYEE

Section 3. As used in this Bond, "Employee" means any natural person (except a director or trustee of the Insured, if a corporation, who is not also an officer or employee thereof in some other capacity), while in the regular service of the Insured in the ordinary course of the Insured's business during the Bond Period and whom the Insured compensates by salary, wages or commissions and has the right to govern and direct in the performance of such service, but does not mean any broker factor, commission merchant, consignee, contractor or other agent or representative of the same general character. The words "while in the regular service of the Insured" shall include the first 30 days thereafter; subject, however, to Section 12 and 13.

## LOSS CAUSED BY UNIDENTIFIABLE EMPLOYEES

Section 4. If a loss is alleged to have been caused by the fraud or dishonesty of any one or more of the Employees and the Insured shall be unable to designate the specific Employee or Employees causing such loss, the Insured shall nevertheless have the benefit of this Bond subject to the provisions of Section 2 of this Bond, provided that the evidence submitted reasonably proves that the loss was in fact due to the fraud or dishonesty of one or more of the said Employees, and provided, further, that the aggregate liability of the Underwriter for any such loss shall not exceed the amount stated in Item 3 of the Declarations.

## OWNERSHIP OF MONEY OR OTHER PROPERTY

Section 5. The Insured property may be owned by the Insured, or held by the Insured in any capacity whether or not the Insured is liable for the loss thereof, or may be property as respects which the Insured is legally liable.

## PRIOR FRAUD, DISHONESTY OR CANCELLATION

Section 6. The coverage of this Bond shall not apply to any Employee from and after the time that the Insured or any partner or officer thereof not in collusion with such Employee shall have knowledge or information that such Employee has committed any fraudulent or dishonest act in the service of the Insured or otherwise, whether such act be committed before or after the date of employment by the Insured.

If, prior to the issuance of this Bond, any fidelity insurance in favor of the Insured or any predecessor in interest of the Insured and covering one or more of the Insured's Employees shall have been cancelled as to any of such Employees by reason of the giving of written notice of cancellation by the insurer issuing such fidelity insurance, whether the Underwriter or not, and if such Employees shall not have been reinstated under the coverage of such fidelity insurance or superseding fidelity insurance, the Underwriter shall not be liable on account of such Employees unless the Underwriter shall agree in writing to include such Employees within the coverage of this Bond.

## LOSS – NOTICE – PROOF – ACTION AGAINST UNDERWRITER

Section 7. Upon knowledge or discovery of loss under this Bond, the Insured shall (a) give notice thereof as soon as practicable to the Underwriter or any of its authorized agents, and (b) file detailed proof of loss, duly sworn to, with the Underwriter within four months after the discovery of loss.

Upon the Underwriter's request, the Insured shall produce for the Underwriter's examination all pertinent records, at such reasonable times and places as the Underwriter shall designate, and shall cooperate with the Underwriter in all matters pertaining to loss or claims with respect thereto.

No action shall lie against the Underwriter unless, as a condition precedent thereto, there shall have been full compliance with all the terms of this Bond, nor until ninety days after the required proofs of loss have been filed with the Underwriter, nor at all unless commenced within two years from the date when the Insured discovers the loss. If any limitation of time for notice of loss or any legal proceeding herein contained is shorter than that permitted to be fixed by agreement under any statute controlling the construction of the Bond, the shortest permissible statutory limitation of time shall govern and shall supersede the time limitation herein stated.

## RECOVERIES

Section 8. If the Insured shall sustain any loss covered by this Bond which exceeds the amount of indemnity provided by this Bond, the Insured shall be entitled to all recoveries (except from suretyship, insurance, reinsurance, security or indemnity taken by or for the benefit of the Underwriter) by whomsoever made, on account of such loss under this Bond until fully reimbursed, less the actual cost of effecting the same, and any remainder shall be applied to the reimbursement of the Underwriter.

## LIMITS OF LIABILITY

Section 9. Indemnification by the Underwriter for any loss under this Bond shall not reduce the Underwriter's liability for other losses under this Bond whenever sustained. The Underwriter's total liability under this Bond for any loss caused by any Employee or in which such Employee is concerned or implicated is limited to the amount stated in Item 3 of the Declarations.

Regardless of the number of years this Bond shall continue in force and the number of premiums which shall be payable or paid, the limit of liability stated in Item 3 of the Declarations shall not be cumulative from year to year or period to period.

#### LIMIT OF LIABILITY UNDER THIS BOND AND PRIOR INSURANCE

Section 10. With respect to loss caused by any Employee or in which such Employee is concerned or implicated or which is chargeable to any Employee as provided in Section 4 and which occurs partly during the Bond Period and partly during the period of other bonds or policies issued by the Underwriter to the Insured or to any predecessor in interest of the Insured and terminated or cancelled or allowed to expire and in which the period for discovery has not expired at the time any such loss thereunder is discovered, the total liability of the Underwriter under this Bond and under such other bonds or policies shall not exceed, in the aggregate, the amount stated in Item 3 of the Declarations or the amount available to the Insured under such other bonds or policies, as limited by the terms and conditions thereof, for any such loss, if the latter amount be the larger.

#### OTHER INSURANCE

Section 11. If there is available to the Insured any other insurance or indemnity covering any loss covered by this Bond, the Underwriter shall be liable hereunder only for that part of such loss which is in excess of the amount recoverable or recovered from such other insurance or indemnity.

#### CANCELLATION AS TO ANY EMPLOYEE

Section 12. This Bond shall be deemed cancelled as to any Employee (a) immediately upon discovery by the Insured, or by any partner or officer thereof not in collusion with such Employee, or any fraudulent or dishonest act on the part of such Employee; or (b) at 12:01 A.M. standard time as aforesaid, upon the effective date specified in a written notice mailed to the Insured. Such date shall be not less than fifteen days after the date of mailing. The mailing by the Underwriter of notice as aforesaid to the Insured at the address shown in this Bond shall be sufficient proof of notice. Delivery of such written notice by the Underwriter shall be equivalent to mailing.

#### CANCELLATION OF BOND

Section 13. The First Named Insured shown in item 1 may cancel this bond by mailing or delivering to us advance written notice of cancellation. We may cancel this bond by mailing or delivering to the First Named Insured shown in item 1 written notice of cancellation at least 10 days before the cancellation date if for non-payment of any premium due to us or 75 days before the effective date of cancellation but in no event less than the minimum Statutory time permitted by State Law. We will mail or deliver our notice to the First Named Insured's last mailing address known to us. Notice of cancellation will state the effective date of cancellation. The Bond Period will end on that date. If this bond is cancelled, we will send the First Named Insured any premium refund due calculated on a pro rata basis, but always subject to a minimum premium. If notice is mailed, proof of mailing will be sufficient proof of notice.

In witness whereof, the Underwriter has caused this Bond to be executed on the Declaration page.

<b>State:</b>	District of Columbia	<b>First Filing Company:</b>	Capitol Indemnity Corporation, ...
<b>TOI/Sub-TOI:</b>	23.0 Fidelity/23.0000 Fidelity		
<b>Product Name:</b>	Fidelity Application & Bond Form Revision		
<b>Project Name/Number:</b>	Fidelity Application & Bond Form Revision/18-FID-FO-CW-044		

## Supporting Document Schedules

<b>Bypassed - Item:</b>	Readability Certificate
<b>Bypass Reason:</b>	n/a
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Copy of Trust Agreement
<b>Bypass Reason:</b>	n/a
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Consulting Authorization
<b>Bypass Reason:</b>	n/a
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Side by Side
<b>Comments:</b>	
<b>Attachment(s):</b>	FAP 007-DC Side by Side.pdf FBD 002-ERISA Side by Side.pdf FAP 001-BSB Side by Side.pdf FAP 002-ERISA Side by Side.pdf FAP 003-R Side by Side.pdf FAP 005-DC Side by Side.pdf FAP 006-DC Side by Side.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

~~<Company Name>~~  
~~<Service Office Location>~~

**~~DISTRICT OF COLUMBIA~~ APPLICATION FOR CRIME PROTECTION POLICY**  
 COMPREHENSIVE UNDERWRITING & RATING SURVEY

~~Policy Coverage offered: Crime Protection Policy Loss Sustained form~~

~~Named Insured:~~ \_\_\_\_\_  
~~Principal Address:~~ \_\_\_\_\_  
~~If EXCESS~~ enter Primary Policy # and carrier: \_\_\_\_\_

**1. OPERATIONS:**

**Public Entities:** Are you a: State ☐ County ☐ City/Town ☐ Other Political Subdivision ☐  
**Mercantile Entities:** Are you a: Corporation ☐ Partnership ☐ Individual ☐

**1. Type of Operation/Business Description:** \_\_\_\_\_  
**2. Date Established:** \_\_\_\_\_

**2. INTERNAL CONTROLS:**

1. Is an audit performed each year? YES ☐ NO ☐  
**How Prepared?** In-House ☐ Independent CPA ☐ **Scope?** Audit ☐ Review ☐ Compilation ☐

***If coverage desired is at \$250,000; please submit a copy of the annual financial report.***

2. Are bank accounts reconciled by someone not authorized to deposit or withdraw therefrom? YES ☐ NO ☐  
 How Often? \_\_\_\_\_

3. Will all checks issued by the insured be countersigned? YES ☐ NO ☐  
 If no, who signs? (Name and position) \_\_\_\_\_

4. Prior Insurance? YES ☐ NO ☐ Name of carrier if "Yes": \_\_\_\_\_

5. Prior Losses? YES ☐ NO ☐ If Yes, Amount: \$ \_\_\_\_\_ (**attach details of loss**)

6. Do you have (use) funds transfer transactions (i.e. Wire Transfers, ACH, EFT, etc.)? YES ☐ NO ☐  
 If "Yes", how often are funds transfer transactions reconciled? \_\_\_\_\_  
 Are they reconciled by someone not authorized to approve, initiate or handle them? YES ☐ NO ☐

7. Does supporting documentation accompany all checks to be signed? YES ☐ NO ☐  
 If "No", Explain: \_\_\_\_\_

8. Are your employees required to take at least 1 or 2 consecutive weeks of vacation? YES ☐ NO ☐

**3. INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES:**

<u>Insuring Agreement</u>	<u>Limit of Insurance</u>	<u>Deductible Amount</u>
Employee Dishonesty	\$ _____	\$ _____
Forgery or Alteration	\$ _____	\$ _____
Loss of Clients' Property	\$ _____	\$ _____

**4. RATING DATA:**

1. Enter the # of: **Officers/Officials:** \_\_\_\_\_ **Employees, other than Officers/Officials:** \_\_\_\_\_  
 2. Enter the # of employees that have custody of, or access to, **property of your clients:** \_\_\_\_\_

**5. For PUBLIC ENTITY Insureds:**

**PLEASE NOTE: Persons required by law to be individually bonded and Treasurers and Tax Collectors by whatever title known are excluded from coverage under Employee Dishonesty.**

**1. Is Faithful Performance of Duty Coverage desired?** YES ☐ NO ☐  
 If "YES", enter the number of your Patrolmen/women: \_\_\_\_\_



Surety & Fidelity Bond Department, P.O. Box 5900, Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## APPLICATION FOR CRIME PROTECTION POLICY COMPREHENSIVE UNDERWRITING & RATING SURVEY

**Named Insured:** \_\_\_\_\_

**Principal Address:** \_\_\_\_\_

Policy Coverage offered: Crime Protection Policy for Public Entities ***Loss Sustained form***

**This policy will be Primary** ☐ **Excess** ☐ **If EXCESS, enter Primary Policy # and carrier:** \_\_\_\_\_

### 1. OPERATIONS:

**Public Entities:** Are you a: State ☐ County ☐ City/Town ☐ Other Political Subdivision ☐

**Mercantile Entities:** Are you a: Corporation ☐ Partnership ☐ Individual ☐

**1. Type of Operation/Business Description:** \_\_\_\_\_

**2. Date Established:** \_\_\_\_\_

### 2. INTERNAL CONTROLS:

1. Is an audit performed each year? YES ☐ NO ☐

**How Prepared?** In-House ☐ Independent CPA ☐ **Scope?** Audit ☐ Review ☐ Compilation ☐

***If coverage desired is at \$250,000; please submit a copy of the annual financial report.***

2. Are bank accounts reconciled by someone not authorized to deposit or withdraw therefrom? YES ☐ NO ☐  
How Often? \_\_\_\_\_

3. Will all checks issued by the insured be countersigned? YES ☐ NO ☐  
If no, who signs? (Name and position) \_\_\_\_\_

4. Prior Insurance? YES ☐ NO ☐ Name of carrier if "Yes": \_\_\_\_\_

5. Prior Losses? YES ☐ NO ☐ If Yes, Amount: \$ \_\_\_\_\_ ***(attach details of loss)***

6. Do you have (use) funds transfer transactions (i.e. Wire Transfers, ACH, EFT, etc.)? YES ☐ NO ☐  
If "Yes", how often are funds transfer transactions reconciled? \_\_\_\_\_

Are they reconciled by someone not authorized to approve, initiate or handle them? YES ☐ NO ☐

7. Does supporting documentation accompany all checks to be signed? YES ☐ NO ☐  
If "No", Explain: \_\_\_\_\_

8. Are your employees required to take at least 1 or 2 consecutive weeks of vacation? YES ☐ NO ☐

### 3. INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES:

<u>Insuring Agreement</u>	<u>Limit of Insurance</u>	<u>Deductible Amount</u>
Employee Dishonesty	\$ _____	\$ _____
Forgery or Alteration	\$ _____	\$ _____
Loss of Clients' Property	\$ _____	\$ _____

### 4. RATING DATA:

1. Enter the # of: **Officers/Officials:** \_\_\_\_\_ **Employees, other than Officers/Officials:** \_\_\_\_\_

2. Enter the # of employees that have custody of, or access to, **property of your clients:** \_\_\_\_\_

### 5. For PUBLIC ENTITY Insureds:

**PLEASE NOTE: Persons required by law to be individually bonded and Treasurers and Tax Collectors by whatever title known are excluded from coverage under Employee Dishonesty.**

**1. Is Faithful Performance of Duty Coverage desired?** YES ☐ NO ☐  
If "YES", enter the number of your Patrolmen/women: \_\_\_\_\_

**READ CAREFULLY AND SIGN**

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgement of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The individuals and/or organizations indicated below hereby agree that any electronic signatures (including facsimile signatures) utilized in connection with the execution of this document shall be considered originals and be fully binding and enforceable. Further, the use of any electronic signature by a party shall be evidence of that party's intent to be bound to the terms of such document. The parties agree that they shall not raise any defense (statutory or otherwise) to the enforceability of this document based upon the fact an electronic signature has been used.

**FRAUD STATEMENT**

~~ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.~~

~~Signed at~~ \_\_\_\_\_ ~~Insured:~~ \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

**SUBMITTING AGENT'S INFORMATION**

~~Name:~~ \_\_\_\_\_ ~~License Number:~~ \_\_\_\_\_

~~Mailing Address:~~ \_\_\_\_\_

~~Phone:~~ \_\_\_\_\_ ~~Contact:~~ \_\_\_\_\_

**READ CAREFULLY AND SIGN**

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgement of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The individuals and/or organizations indicated below hereby agree that any electronic signatures (including facsimile signatures) utilized in connection with the execution of this document shall be considered originals and be fully binding and enforceable. Further, the use of any electronic signature by a party shall be evidence of that party's intent to be bound to the terms of such document. The parties agree that they shall not raise any defense (statutory or otherwise) to the enforceability of this document based upon the fact an electronic signature has been used.

**FRAUD STATEMENT:****APPLICABLE IN: AL AR DC IL A MD NM RI AND WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

\*Applies in MD only.

**APPLICABLE IN: CO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**APPLICABLE IN: FL AND OK**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.

**APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only.

**APPLICABLE IN: ME, TN, VA AND WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME only.

**APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICABLE IN: OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.





Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

## &lt;Company Name&gt;

Mailing Address: P.O. Box 5900, Madison, WI 53705-0900

Bond No. \_\_\_\_\_

**EMPLOYEE DISHONESTY BOND**

as required by The Employee Retirement Income Security Act of 1974 (ERISA)

~~DECLARATIONS~~~~Item 1. Name of Insured:~~ \_\_\_\_\_~~(HEREIN CALLED THE INSURED)~~~~Principal Address:~~ \_\_\_\_\_~~(NUMBER, STREET)~~~~(CITY, STATE, ZIP)~~

Item 2. Bond Period: From 12:01 A.M. on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ to 12:01 A.M. on the effective date of the cancellation or termination of this Bond, standard time at the Principal Address as to each of said dates.

Item 3. Limit of Liability: \_\_\_\_\_ Dollars (\$ \_\_\_\_\_ ).  
(MAXIMUM LIMIT IS \$500,000)

- a. In consideration of the additional premium charged if, at the inception of this policy, you have a Limit of Liability for your Plan that is equal to or greater than that required under ERISA, we agree to automatically increase that Limit of Liability, subject, however, to the Non-Cumulation of Limits in section 9 of the GENERAL CONDITIONS, and subject to a maximum limit of \$500,000. Inflation guard accepted. ☐ YES ☐ NO

Item 4. The liability of the Underwriter is subject to the terms and conditions hereby attached.

Item 5. The Insured by the acceptance of this bond gives notice to the Underwriter terminating or cancelling prior bonds or policy(ies) No.(s). Such termination or cancellation to be effective as of the time this bond becomes effective. To the extent that coverage in this bond replaces coverage in other bonds terminating on the inception date of this bond, coverage under this bond shall not become effective until such other coverage has terminated.

Item 6. In compliance with certain provisions of the Employee Retirement Income Security Act (ERISA):

1. ~~"Employee" also includes any natural person who is:~~  
 a. ~~A trustee, an officer, employee, administrator or a manager, except an administrator or manager who is an independent contractor, of any Employee Welfare or Pension Benefit Plan (hereafter called Plan) insured under this insurance, and~~  
 b. ~~A director or trustee while that person is handling funds or other property of any Plan insured under this insurance.~~

Item 7. If two or more Plans are insured under this insurance, any payment for loss:

- a. Sustained by two or more Plans or  
 b. Of commingled funds or other property of two or more Plans  
 that arises out of one "occurrence", is to be shared by each Plan sustaining the loss in the proportion that the amount of insurance required for each Plan under ERISA provision bears to the total of those amounts.

Item 8. **Certain Computer Errors:** loss, or any part thereof, resulting directly from the failure of any computer, computer system or component thereof, embedded chip, microprocessor, or similar electronic device correctly to recognize, interpret or accept a date which is subsequent to December 31, 1999 or accurately to process data or perform any other function because of such a failure. This exclusion applies without regard to ownership of the computer, computer system, chip, microprocessor or similar device; whether or not another cause or event also contributed to the loss; and to the cost of any test, diagnosis, repair, advice, design, or re-programming to discover, guard against or correct such a failure. Provided, however, that this Exclusion shall not apply to any loss or part thereof as to which You can establish coverage under employee dishonesty and the amount of the loss, without reliance upon such a failure.

Cancellation of prior insurance: By acceptance of this policy you give us notice canceling prior policy or bond Nos. \_\_\_\_\_ the cancellation to be effective at the time this policy becomes effective.

SIGNED AND DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_.

Underwriting Service Office Address:  
<Service Office Location>BY: \_\_\_\_\_  
Signature of Authorized Representative\_\_\_\_\_  
Print or Type Name of Authorized Representative*Power of Attorney is not required to execute this bond.*

## &lt;Company Name&gt;

Mailing Address: P.O. Box 5900, Madison, WI 53705-0900

Bond No. \_\_\_\_\_

**EMPLOYEE DISHONESTY BOND**as required by The Employee Retirement Income Security Act of 1974 (ERISA) as amendedDECLARATIONSItem 1 Name of Employee Benefit Plans:(HEREIN CALLED THE INSURED)Principal Address:(NUMBER STREET)(CITY, STATE, ZIP)Item 1a Plan Sponsor:(HEREIN CALLED THE INSURED)Plan Sponsor Address:(NUMBER, STREET)(CITY, STATE, ZIP)

Item 2. Bond Period: From 12:01 A.M. on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ to 12:01 A.M. on the effective date of the cancellation or termination of this Bond, standard time at the Principal Address as to each of said dates.

Item 3. Limit of Liability: \_\_\_\_\_ Dollars (\$ \_\_\_\_\_ ).  
(MAXIMUM LIMIT IS \$500,000)

- a. In consideration of the additional premium charged if, at the inception of this policy, you have a Limit of Liability for your Plan that is equal to or greater than that required under ERISA, we agree to automatically increase that Limit of Liability, subject, however, to the Non-Cumulation of Limits in section 9 of the GENERAL CONDITIONS, and subject to a maximum limit of \$500,000. Inflation guard accepted. ☐ YES ☐ NO

Item 4. The liability of the Underwriter is subject to the terms and conditions hereby attached.

Item 5. The Insured by the acceptance of this bond gives notice to the Underwriter terminating or cancelling prior bonds or policy(ies) No.(s). Such termination or cancellation to be effective as of the time this bond becomes effective. To the extent that coverage in this bond replaces coverage in other bonds terminating on the inception date of this bond, coverage under this bond shall not become effective until such other coverage has terminated.

Item 6. In compliance with certain provisions of the Employee Retirement Income Security Act (ERISA):

1. Covered person means any natural person who is

- a. a trustee, officer, employee, administrator or manager, except an administrator or manager who is an independent contractor, of any employee benefit plan(s) insured under this insurance; or  
b. a director, officer, employee or trustee of the Plan Sponsor, but only while that person is handling money, securities or other property of an employee benefit plan insured under this insurance;

Item 7. If two or more Plans are insured under this insurance, any payment for loss:

- a. Sustained by two or more Plans or  
 b. Of commingled funds or other property of two or more Plans  
 that arises out of one "occurrence", is to be shared by each Plan sustaining the loss in the proportion that the amount of insurance required for each Plan under ERISA provision bears to the total of those amounts.

Item 8. **Certain Computer Errors:** loss, or any part thereof, resulting directly from the failure of any computer, computer system or component thereof, embedded chip, microprocessor, or similar electronic device correctly to recognize, interpret or accept a date which is subsequent to December 31, 1999 or accurately to process data or perform any other function because of such a failure. This exclusion applies without regard to ownership of the computer, computer system, chip, microprocessor or similar device; whether or not another cause or event also contributed to the loss; and to the cost of any test, diagnosis, repair, advice, design, or re-programming to discover, guard against or correct such a failure. Provided, however, that this Exclusion shall not apply to any loss or part thereof as to which You can establish coverage under employee dishonesty and the amount of the loss, without reliance upon such a failure.

To be attached to and form a part of an Employee Dishonesty Bond as required by The Employee Retirement Income Security Act of 1974 (ERISA).

### INSURING AGREEMENT

~~The Underwriter, in consideration of the payment of the premium, and subject to the Declarations made a part hereof, the General Agreement, Conditions, and Limitations, and other terms of this Bond, agrees to indemnify the Insured against loss of money or other property which the Insured shall sustain resulting directly from one or more fraudulent or dishonest acts of any Employee, acting alone or in collusion with others to an amount not to exceed in the aggregate the amount stated in Item 3 of the Declarations. Dishonest or fraudulent acts as used in this Insurance Agreement shall mean only dishonest or fraudulent acts committed by such Employee with the manifest intent to cause the Insured to sustain such loss and to obtain financial benefit for the Employee, or for any other person or organization intended by the Employee to receive such benefit, other than salaries, commissions, fees, bonuses, promotions, awards, profit sharing, pensions or other employee benefits earned in the normal course of employment.~~

### GENERAL AGREEMENTS

#### CONSOLIDATION-MERGER

- A. If, through consolidation or merger with, or purchase of assets of, some other concern, any person shall become Employees, the Insured shall give the Underwriter written notice thereof and shall pay an additional premium computed pro rata from the date of such consolidation, merger or purchase to the end of the current premium period.

#### JOINT INSURED

- B. If more than one Insured is covered under this Bond, the Insured first named shall act for itself and for every other Insured for all purposes of this Bond. Knowledge possessed or discovery made by any Insured or by any partner or officers thereof shall, for the purposes of Section 6, 7 and 12, constitute knowledge possessed or discovery made by every Insured. Cancellation of the insurance hereunder as respects any Employee as provided in Section 12 shall apply to every Insured. If, prior to the cancellation or termination of this Bond in its entirety, this Bond is cancelled or terminated as to any Insured, there shall be no liability for any loss sustained by such Insured unless discovered within one year from the date of such cancellation or termination. The liability of the Underwriter for loss sustained by any or all of the Insured shall not exceed the amount for which the Underwriter would be liable had all such loss been sustained by any one of the Insured. Payment by the Underwriter to the Insured first named of any loss under this Bond shall fully release the Underwriter on account of such loss. If the Insured first named ceases for any reason to be covered under this Bond, then the Insured next named shall thereafter be considered as the Insured first named for all purposes of this Bond.

#### LOSS UNDER PRIOR BOND OR POLICY

- C. If the coverage of this Bond is substituted for any prior bond or policy of insurance carried by the Insured or by any predecessor in interest of the Insured, which prior bond or policy is terminated, cancelled or allowed to expire as to the time of such substitution the Underwriter agrees that this Bond applies to loss which is discovered as provided in Section 1 of the Conditions and Limitations and which would have been recoverable by the Insured or such predecessor under such prior bond or policy except for the fact that the time within which to discover loss thereunder has expired; provided:
- (1) the indemnity afforded by this General Agreement C shall be a part of and not in addition to the amount of insurance afforded by this Bond.
  - (2) such loss would have been covered under this Bond had this Bond with its agreements, limitations, and conditions as of the time of such substitution been in force when the acts or defaults causing such loss were committed; and
  - (3) recovery under this Bond on account of such loss shall in no event exceed the amount which would have been recoverable under this Bond in the amount for which it is written as of the time of such substitution, had this Bond been in force when such acts or defaults were committed, or the amount which would have been recoverable under such prior bond or policy had such prior bond or policy continued in force until the discovery of such loss, if the latter amount be smaller.

### THE FOREGOING INSURING AGREEMENT AND GENERAL AGREEMENTS ARE SUBJECT TO THE FOLLOWING CONDITIONS AND LIMITATIONS:

#### BOND PERIOD, TERRITORY, DISCOVERY

Section 1. Loss is covered under this Bond only if discovered not later than one year from the end of the Bond Period.

Subject to General Agreement C, this Bond applies only to loss sustained by the Insured through fraudulent or dishonest acts committed during the Bond Period by any of the Employees engaged in the regular service of the Insured within any of the States of the United States of America, the District of Columbia, Virgin Islands, Puerto Rico, Canal Zone or Canada or while such Employees are elsewhere for a limited period.

#### EXCLUSION

Section 2. This Bond does not apply to loss, or to that part of any loss, as the case may be, the proof of which, either as to its factual existence or as to its amount, is dependent upon an inventory computation or a profit and loss computation: provided, however, that this paragraph shall not apply to loss of money or other property which the Insured can prove, through evidence wholly apart from such computations, is sustained by the Insured through any fraudulent or dishonest act or acts committed by any one or more of the Employees. This Bond does not apply to the defense of any legal proceeding brought against the Insured or to fees, costs or expenses incurred or paid by the Insured in prosecuting or defending any legal proceeding whether or not such proceeding results or would result in a loss to the Insured covered by this Bond.

#### DEFINITION OF EMPLOYEE

Section 3. As used in this Bond, "Employee" means any natural person (except a director or trustee of the Insured, if a corporation, who is not also an officer or employee thereof in some other capacity), while in the regular service of the Insured in the ordinary course of the Insured's business during the Bond Period and whom the Insured compensates by salary, wages or commissions and has the right to govern and direct in the performance of such service, but does not mean any broker factor, commission merchant, consignee, contractor or other agent or representative of the same general character. The words "while in the regular service of the Insured" shall include the first 30 days thereafter; subject, however, to Section 12 and 13.

#### LOSS CAUSED BY UNIDENTIFIABLE EMPLOYEES

Section 4. If a loss is alleged to have been caused by the fraud or dishonesty of any one or more of the Employees and the Insured shall be unable to designate the specific Employee or Employees causing such loss, the Insured shall nevertheless have the benefit of this Bond subject to the provisions of Section 2 of this Bond, provided that the evidence submitted reasonably proves that the loss was in fact due to the fraud or dishonesty of one or more of the said Employees, and provided, further, that the aggregate liability of the Underwriter for any such loss shall not exceed the amount stated in Item 3 of the Declarations.

Cancellation of prior insurance: By acceptance of this policy you give us notice canceling prior policy or bond Nos. \_\_\_\_\_ the cancellation to be effective at the time this policy becomes effective.

SIGNED AND DATED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_.

Underwriting Service Office Address:  
<Service Office Location>

BY: \_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Print or Type Name of Authorized Representative

*Power of Attorney is not required to execute this bond.*

To be attached to and form a part of an Employee Dishonesty Bond as required by The Employee Retirement Income Security Act of 1974 (ERISA).

### INSURING AGREEMENT

#### FRAUD OR DISHONESTY

We will pay for loss of money, securities or other property resulting directly from fraud or dishonesty committed by a covered person.

### GENERAL AGREEMENTS

#### CONSOLIDATION-MERGER

- A. If, through consolidation or merger with, or purchase of assets of, some other concern, any person shall become Employees, the Insured shall give the Underwriter written notice thereof and shall pay an additional premium computed pro rata from the date of such consolidation, merger or purchase to the end of the current premium period.

#### JOINT INSURED

- B. If more than one Insured is covered under this Bond, the Insured first named shall act for itself and for every other Insured for all purposes of this Bond. Knowledge possessed or discovery made by any Insured or by any partner or officers thereof shall, for the purposes of Section 6, 7 and 12, constitute knowledge possessed or discovery made by every Insured. Cancellation of the insurance hereunder as respects any Employee as provided in Section 12 shall apply to every Insured. If, prior to the cancellation or termination of this Bond in its entirety, this Bond is cancelled or terminated as to any Insured, there shall be no liability for any loss sustained by such Insured unless discovered within one year from the date of such cancellation or termination. The liability of the Underwriter for loss sustained by any or all of the Insured shall not exceed the amount for which the Underwriter would be liable had all such loss been sustained by any one of the Insured. Payment by the Underwriter to the Insured first named of any loss under this Bond shall fully release the Underwriter on account of such loss. If the Insured first named ceases for any reason to be covered under this Bond, then the Insured next named shall thereafter be considered as the Insured first named for all purposes of this Bond.

#### LOSS UNDER PRIOR BOND OR POLICY

- C. If the coverage of this Bond is substituted for any prior bond or policy of insurance carried by the Insured or by any predecessor in interest of the Insured, which prior bond or policy is terminated, cancelled or allowed to expire as to the time of such substitution the Underwriter agrees that this Bond applies to loss which is discovered as provided in Section 1 of the Conditions and Limitations and which would have been recoverable by the Insured or such predecessor under such prior bond or policy except for the fact that the time within which to discover loss thereunder has expired; provided:
- (1) the indemnity afforded by this General Agreement C shall be a part of and not in addition to the amount of insurance afforded by this Bond.
  - (2) such loss would have been covered under this Bond had this Bond with its agreements, limitations, and conditions as of the time of such substitution been in force when the acts or defaults causing such loss were committed; and
  - (3) recovery under this Bond on account of such loss shall in no event exceed the amount which would have been recoverable under this Bond in the amount for which it is written as of the time of such substitution, had this Bond been in force when such acts or defaults were committed, or the amount which would have been recoverable under such prior bond or policy had such prior bond or policy continued in force until the discovery of such loss, if the latter amount be smaller.

### THE FOREGOING INSURING AGREEMENT AND GENERAL AGREEMENTS ARE SUBJECT TO THE FOLLOWING CONDITIONS AND LIMITATIONS:

#### BOND PERIOD, TERRITORY, DISCOVERY

Section 1. Loss is covered under this Bond only if discovered not later than one year from the end of the Bond Period. This policy covers only acts committed or events occurring within the United States of America.

Subject to General Agreement C, this Bond applies only to loss sustained by the Insured through fraudulent or dishonest acts committed during the Bond Period by any of the Employees engaged in the regular service of the Insured within any of the States of the United States of America, the District of Columbia, Virgin Islands, Puerto Rico, Canal Zone or Canada or while such Employees are elsewhere for a limited period.

**OWNERSHIP OF MONEY OR OTHER PROPERTY**

Section 5. The Insured property may be owned by the Insured, or held by the Insured in any capacity whether or not the Insured is liable for the loss thereof, or may be property as respects which the Insured is legally liable.

**PRIOR FRAUD, DISHONESTY OR CANCELLATION**

Section 6. The coverage of this Bond shall not apply to any Employee from and after the time that the Insured or any partner or officer thereof not in collusion with such Employee shall have knowledge or information that such Employee has committed any fraudulent or dishonest act in the service of the Insured or otherwise, whether such act be committed before or after the date of employment by the Insured.

If, prior to the issuance of this Bond, any fidelity insurance in favor of the Insured or any predecessor in interest of the Insured and covering one or more of the Insured's Employees shall have been cancelled as to any of such Employees by reason of the giving of written notice of cancellation by the insurer issuing such fidelity insurance, whether the Underwriter or not, and if such Employees shall not have been reinstated under the coverage of such fidelity insurance or superseding fidelity insurance, the Underwriter shall not be liable on account of such Employees unless the Underwriter shall agree in writing to include such Employees within the coverage of this Bond.

**LOSS – NOTICE – PROOF – ACTION AGAINST UNDERWRITER**

Section 7. Upon knowledge or discovery of loss under this Bond, the Insured shall (a) give notice thereof as soon as practicable to the Underwriter or any of its authorized agents, and (b) file detailed proof of loss, duly sworn to, with the Underwriter within four months after the discovery of loss.

Upon the Underwriter's request, the Insured shall produce for the Underwriter's examination all pertinent records, at such reasonable times and places as the Underwriter shall designate, and shall cooperate with the Underwriter in all matters pertaining to loss or claims with respect thereto.

No action shall lie against the Underwriter unless, as a condition precedent thereto, there shall have been full compliance with all the terms of this Bond, nor until ninety days after the required proofs of loss have been filed with the Underwriter, nor at all unless commenced within two years from the date when the Insured discovers the loss. If any limitation of time for notice of loss or any legal proceeding herein contained is shorter than that permitted to be fixed by agreement under any statute controlling the construction of the Bond, the shortest permissible statutory limitation of time shall govern and shall supersede the time limitation herein stated.

**RECOVERIES**

Section 8. If the Insured shall sustain any loss covered by this Bond which exceeds the amount of indemnity provided by this Bond, the Insured shall be entitled to all recoveries (except from suretyship, insurance, reinsurance, security or indemnity taken by or for the benefit of the Underwriter) by whomsoever made, on account of such loss under this Bond until fully reimbursed, less the actual cost of effecting the same, and any remainder shall be applied to the reimbursement of the Underwriter.

**LIMITS OF LIABILITY**

Section 9. Indemnification by the Underwriter for any loss under this Bond shall not reduce the Underwriter's liability for other losses under this Bond whenever sustained. The Underwriter's total liability under this Bond for any loss caused by any Employee or in which such Employee is concerned or implicated is limited to the amount stated in Item 3 of the Declarations.

Regardless of the number of years this Bond shall continue in force and the number of premiums which shall be payable or paid, the limit of liability stated in Item 3 of the Declarations shall not be cumulative from year to year or period to period.

**LIMIT OF LIABILITY UNDER THIS BOND AND PRIOR INSURANCE**

Section 10. With respect to loss caused by any Employee or in which such Employee is concerned or implicated or which is chargeable to any Employee as provided in Section 4 and which occurs partly during the Bond Period and partly during the period of other bonds or policies issued by the Underwriter to the Insured or to any predecessor in interest of the Insured and terminated or cancelled or allowed to expire and in which the period for discovery has not expired at the time any such loss thereunder is discovered, the total liability of the Underwriter under this Bond and under such other bonds or policies shall not exceed, in the aggregate, the amount stated in Item 3 of the Declarations or the amount available to the Insured under such other bonds or policies, as limited by the terms and conditions thereof, for any such loss, if the latter amount be the larger.

**OTHER INSURANCE**

Section 11. If there is available to the Insured any other insurance or indemnity covering any loss covered by this Bond, the Underwriter shall be liable hereunder only for that part of such loss which is in excess of the amount recoverable or recovered from such other insurance or indemnity.

**CANCELLATION AS TO ANY EMPLOYEE**

Section 12. This Bond shall be deemed cancelled as to any Employee (a) immediately upon discovery by the Insured, or by any partner or officer thereof not in collusion with such Employee, or any fraudulent or dishonest act on the part of such Employee; or (b) at 12:01 A.M. standard time as aforesaid, upon the effective date specified in a written notice mailed to the Insured. Such date shall be not less than fifteen days after the date of mailing. The mailing by the Underwriter of notice as aforesaid to the Insured at the address shown in this Bond shall be sufficient proof of notice. Delivery of such written notice by the Underwriter shall be equivalent to mailing.

**CANCELLATION OF BOND**

Section 13. The First Named Insured shown in item 1 may cancel this bond by mailing or delivering to us advance written notice of cancellation. We may cancel this bond by mailing or delivering to the First Named Insured shown in item 1 written notice of cancellation at least 10 days before the cancellation date if for non-payment of any premium due to us or 75 days before the effective date of cancellation but in no event less than the minimum Statutory time permitted by State Law. We will mail or deliver our notice to the First Named Insured's last mailing address known to us. Notice of cancellation will state the effective date of cancellation. The Bond Period will end on that date. If this bond is cancelled, we will send the First Named Insured any premium refund due calculated on a pro rata basis, but always subject to a minimum premium. If notice is mailed, proof of mailing will be sufficient proof of notice.

In witness whereof, the Underwriter has caused this Bond to be executed on the Declaration page.



**EXCLUSION**

Section 2. This Bond does not apply to loss, or to that part of any loss, as the case may be, the proof of which, either as to its factual existence or as to its amount, is dependent upon an inventory computation or a profit and loss computation: provided, however, that this paragraph shall not apply to loss of money or other property which the Insured can prove, through evidence wholly apart from such computations, is sustained by the Insured through any fraudulent or dishonest act or acts committed by any one or more of the Employees. This Bond does not apply to the defense of any legal proceeding brought against the Insured or to fees, costs or expenses incurred or paid by the Insured in prosecuting or defending any legal proceeding whether or not such proceeding results or would result in a loss to the Insured covered by this Bond.

**DEFINITION OF EMPLOYEE**

Section 3. As used in this Bond, "Employee" means any natural person (except a director or trustee of the Insured, if a corporation, who is not also an officer or employee thereof in some other capacity), while in the regular service of the Insured in the ordinary course of the Insured's business during the Bond Period and whom the Insured compensates by salary, wages or commissions and has the right to govern and direct in the performance of such service, but does not mean any broker factor, commission merchant, consignee, contractor or other agent or representative of the same general character. The words "while in the regular service of the Insured" shall include the first 30 days thereafter; subject, however, to Section 12 and 13.

**LOSS CAUSED BY UNIDENTIFIABLE EMPLOYEES**

Section 4. If a loss is alleged to have been caused by the fraud or dishonesty of any one or more of the Employees and the Insured shall be unable to designate the specific Employee or Employees causing such loss, the Insured shall nevertheless have the benefit of this Bond subject to the provisions of Section 2 of this Bond, provided that the evidence submitted reasonably proves that the loss was in fact due to the fraud or dishonesty of one or more of the said Employees, and provided, further, that the aggregate liability of the Underwriter for any such loss shall not exceed the amount stated in Item 3 of the Declarations.

**OWNERSHIP OF MONEY OR OTHER PROPERTY**

Section 5. The Insured property may be owned by the Insured, or held by the Insured in any capacity whether or not the Insured is liable for the loss thereof, or may be property as respects which the Insured is legally liable.

**PRIOR FRAUD, DISHONESTY OR CANCELLATION**

Section 6. The coverage of this Bond shall not apply to any Employee from and after the time that the Insured or any partner or officer thereof not in collusion with such Employee shall have knowledge or information that such Employee has committed any fraudulent or dishonest act in the service of the Insured or otherwise, whether such act be committed before or after the date of employment by the Insured.

If, prior to the issuance of this Bond, any fidelity insurance in favor of the Insured or any predecessor in interest of the Insured and covering one or more of the Insured's Employees shall have been cancelled as to any of such Employees by reason of the giving of written notice of cancellation by the insurer issuing such fidelity insurance, whether the Underwriter or not, and if such Employees shall not have been reinstated under the coverage of such fidelity insurance or superseding fidelity insurance, the Underwriter shall not be liable on account of such Employees unless the Underwriter shall agree in writing to include such Employees within the coverage of this Bond.

**LOSS – NOTICE – PROOF – ACTION AGAINST UNDERWRITER**

Section 7. Upon knowledge or discovery of loss under this Bond, the Insured shall (a) give notice thereof as soon as practicable to the Underwriter or any of its authorized agents, and (b) file detailed proof of loss, duly sworn to, with the Underwriter within four months after the discovery of loss.

Upon the Underwriter's request, the Insured shall produce for the Underwriter's examination all pertinent records, at such reasonable times and places as the Underwriter shall designate, and shall cooperate with the Underwriter in all matters pertaining to loss or claims with respect thereto.

No action shall lie against the Underwriter unless, as a condition precedent thereto, there shall have been full compliance with all the terms of this Bond, nor until ninety days after the required proofs of loss have been filed with the Underwriter, nor at all unless commenced within two years from the date when the Insured discovers the loss. If any limitation of time for notice of loss or any legal proceeding herein contained is shorter than that permitted to be fixed by agreement under any statute controlling the construction of the Bond, the shortest permissible statutory limitation of time shall govern and shall supersede the time limitation herein stated.

**RECOVERIES**

Section 8. If the Insured shall sustain any loss covered by this Bond which exceeds the amount of indemnity provided by this Bond, the Insured shall be entitled to all recoveries (except from suretyship, insurance, reinsurance, security or indemnity taken by or for the benefit of the Underwriter) by whomsoever made, on account of such loss under this Bond until fully reimbursed, less the actual cost of effecting the same, and any remainder shall be applied to the reimbursement of the Underwriter.

**LIMITS OF LIABILITY**

Section 9. Indemnification by the Underwriter for any loss under this Bond shall not reduce the Underwriter's liability for other losses under this Bond whenever sustained. The Underwriter's total liability under this Bond for any loss caused by any Employee or in which such Employee is concerned or implicated is limited to the amount stated in Item 3 of the Declarations.





Regardless of the number of years this Bond shall continue in force and the number of premiums which shall be payable or paid, the limit of liability stated in Item 3 of the Declarations shall not be cumulative from year to year or period to period.

#### LIMIT OF LIABILITY UNDER THIS BOND AND PRIOR INSURANCE

Section 10. With respect to loss caused by any Employee or in which such Employee is concerned or implicated or which is chargeable to any Employee as provided in Section 4 and which occurs partly during the Bond Period and partly during the period of other bonds or policies issued by the Underwriter to the Insured or to any predecessor in interest of the Insured and terminated or cancelled or allowed to expire and in which the period for discovery has not expired at the time any such loss thereunder is discovered, the total liability of the Underwriter under this Bond and under such other bonds or policies shall not exceed, in the aggregate, the amount stated in Item 3 of the Declarations or the amount available to the Insured under such other bonds or policies, as limited by the terms and conditions thereof, for any such loss, if the latter amount be the larger.

#### OTHER INSURANCE

Section 11. If there is available to the Insured any other insurance or indemnity covering any loss covered by this Bond, the Underwriter shall be liable hereunder only for that part of such loss which is in excess of the amount recoverable or recovered from such other insurance or indemnity.

#### CANCELLATION AS TO ANY EMPLOYEE

Section 12. This Bond shall be deemed cancelled as to any Employee (a) immediately upon discovery by the Insured, or by any partner or officer thereof not in collusion with such Employee, or any fraudulent or dishonest act on the part of such Employee; or (b) at 12:01 A.M. standard time as aforesaid, upon the effective date specified in a written notice mailed to the Insured. Such date shall be not less than fifteen days after the date of mailing. The mailing by the Underwriter of notice as aforesaid to the Insured at the address shown in this Bond shall be sufficient proof of notice. Delivery of such written notice by the Underwriter shall be equivalent to mailing.

#### CANCELLATION OF BOND

Section 13. The First Named Insured shown in item 1 may cancel this bond by mailing or delivering to us advance written notice of cancellation. We may cancel this bond by mailing or delivering to the First Named Insured shown in item 1 written notice of cancellation at least 10 days before the cancellation date if for non-payment of any premium due to us or 75 days before the effective date of cancellation but in no event less than the minimum Statutory time permitted by State Law. We will mail or deliver our notice to the First Named Insured's last mailing address known to us. Notice of cancellation will state the effective date of cancellation. The Bond Period will end on that date. If this bond is cancelled, we will send the First Named Insured any premium refund due calculated on a pro rata basis, but always subject to a minimum premium. If notice is mailed, proof of mailing will be sufficient proof of notice.

In witness whereof, the Underwriter has caused this Bond to be executed on the Declaration page.

~~<Company Name>~~  
~~<Service Office Location>~~

## BUSINESS SERVICE BOND APPLICATION

Agency Name: \_\_\_\_\_ Agency No. \_\_\_\_\_ Bond No. \_\_\_\_\_

Business ~~Name~~ (Must be exactly as it is to appear on the bond)

Phone ~~Number~~ \_\_\_\_\_

~~Address~~ \_\_\_\_\_  
 (street) (city) (state) (zip)

Type of ~~Business~~ \_\_\_\_\_

~~Amount of Bond \$~~ \_\_\_\_\_ ~~Effective Date~~ \_\_\_\_\_

Number of Owners: \_\_\_\_\_

Number of Employees: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

How long have you been in business? \_\_\_\_\_

Do you investigate the employment history of job applicants? ☐ Yes ☐ No If "No", please ~~explain below:~~

Do you perform criminal history background checks on job applicants? ☐ Yes ☐ No If "No", please ~~explain below:~~

Have you had a bond with another surety? ☐ Yes ☐ No If "Yes", what is the reason for changing companies?

Have you had any prior losses of clients' property? ☐ Yes ☐ No If "Yes", please attach details on a separate sheet

### CONVICTION CLAUSE

In order to protect you and your employees against unjustified allegations of dishonesty, the employee must be tried and convicted of the alleged dishonest act in a court of proper jurisdiction before coverage will apply.

### READ CAREFULLY AND SIGN

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The insured represents that the information furnished in this application and any supplemental application is complete, true and correct. Any misrepresentation, omission, concealment or incorrect statement of a material fact, in the application or otherwise, shall be grounds for the rescission of any coverage issued on reliance upon such information. Be aware that the underwriting company has relied on your answers in accepting, rating and issuing your policy and where applicable in certain jurisdictions, this application becomes part of the policy issued to the insured as an endorsement.

The individuals and/or organizations indicated below hereby agree that any electronic signatures (including facsimile signatures) utilized in connection with the execution of this document shall be considered originals and be fully binding and enforceable. Further, the use of any electronic signature by a party shall be evidence of that party's intent to be bound to the terms of such document. The parties agree that they shall not raise any defense (statutory or otherwise) to the enforceability of this document based upon the fact an electronic signature has been used.



Surety & Fidelity Bond Department, P.O. Box 5900, Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## BUSINESS SERVICE BOND APPLICATION

Agency Name:				Agency No.			Bond No.				
Business <u>Name:</u> (Must be exactly as it is to appear on the bond)											
Phone <u>Number:</u>											
<u>Address:</u>											
(street)		(city)			(state)		(zip)				
Type of <u>Business:</u>											
<u>Amount of Bond \$</u>				<u>Effective Date:</u>				Number of Owners:			
Number of Employees:		Full Time				Part Time				How long have you been in business?	
Do you investigate the employment history of job applicants?				<input type="checkbox"/> Yes <input type="checkbox"/> No		If "No", please <u>explain:</u>					
Do you perform criminal history background checks on job applicants?				<input type="checkbox"/> Yes <input type="checkbox"/> No		If "No", please <u>explain:</u>					
Have you had a bond with another surety?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", what is the reason for changing companies? <b><u>(MO applicants DO NOT answer this question)</u></b>							
Have you had any prior losses of clients' property?				<input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", please attach details on a separate sheet					

### CONVICTION CLAUSE

In order to protect you and your employees against unjustified allegations of dishonesty, the employee must be tried and convicted of the alleged dishonest act in a court of proper jurisdiction before coverage will apply.

### READ CAREFULLY AND SIGN

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

The insured represents that the information furnished in this application and any supplemental application is complete, true and correct. Any misrepresentation, omission, concealment or incorrect statement of a material fact, in the application or otherwise, shall be grounds for the rescission of any coverage issued on reliance upon such information. Be aware that the underwriting company has relied on your answers in accepting, rating and issuing your policy and where applicable in certain jurisdictions, this application becomes part of the policy issued to the insured as an endorsement.

The individuals and/or organizations indicated below hereby agree that any electronic signatures (including facsimile signatures) utilized in connection with the execution of this document shall be considered originals and be fully binding and enforceable. Further, the use of any electronic signature by a party shall be evidence of that party's intent to be bound to the terms of such document. The parties agree that they shall not raise any defense (statutory or otherwise) to the enforceability of this document based upon the fact an electronic signature has been used.

**~~FRAUD STATEMENT~~**

~~ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT THAT PERSON TO CRIMINAL AND/OR CIVIL PENALTIES. PENALTIES MAY INCLUDE CONFINEMENT IN PRISON, FINES AND DENIAL OF INSURANCE BENEFITS.~~

~~Signed at~~ \_\_\_\_\_ ~~Insured:~~ \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Title)

\_\_\_\_\_  
(Print Name)

**~~SUBMITTING AGENTS INFORMATION~~**

~~Name:~~ \_\_\_\_\_ ~~License Number:~~ \_\_\_\_\_

~~Mailing Address:~~ \_\_\_\_\_

~~Phone:~~ \_\_\_\_\_ ~~Contact:~~ \_\_\_\_\_

**FRAUD STATEMENT:****APPLICABLE IN: AL AR DC IL IA MD NM RI AND WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. \*Applies in MD only.

**APPLICABLE IN: CO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**APPLICABLE IN: FL AND OK**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.

**APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only.

**APPLICABLE IN: ME, TN, VA AND WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME only.

**APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICABLE IN: OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

~~<Company Name>~~~~Mailing Address: P.O. Box 5000, Madison, WI 53705-0000~~**ERISA BOND APPLICATION**

Name of Plan(s) (exact name of Plan(s) to be covered) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

1. Is the Plan audited annually by a CPA? ☐ YES ☐ NO

If yes, provide name of the CPA firm \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Does an Independent Administrator service the Plan? ☐ YES ☐ NO

If yes, provide name of Administrator \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Please note Independent Administrators will not be covered under Bond unless you contact your Branch Office.*

3. How many trustees are there for the Plan? \_\_\_\_\_

4. Are two signatures required to withdraw from the Plan? ☐ YES ☐ NO (If no, submit to your Branch Office for underwriting)

5. Who reconciles Plan's bank statement? \_\_\_\_\_

6. Who deposits funds in Plan's accounts? \_\_\_\_\_

*(If the same name is listed in both questions 5 and 6, submit application to your Branch Office for underwriting)*

Amount of Bond \$ \_\_\_\_\_

**Qualified** Plan Assets \$ \_\_\_\_\_ Bond amount must be for at least 10% of Qualified Plan Assets. Maximum Bond limit is \$500,000.**Non-Qualified** Plan Assets \$ \_\_\_\_\_ Bond amount must be for 100% of the Non-Qualified Plan Assets.Premium Basis ☐ 1 Year prepaid ☐ 3 Year Prepaid Proposed Effective Date \_\_\_\_\_Is Inflation Guard Coverage desired? ☐ YES ☐ NO

Please call the Branch Office for Authorization on Bonds over \$100,000.

**READ CAREFULLY AND SIGN**

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

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Surety & Fidelity Bond Department PO Box 5900 Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## ERISA BOND APPLICATION

Name of Plan(s) (exact name of Plan(s) to be covered) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

1. Is the Plan audited annually by a CPA? ☐ YES ☐ NO

If yes, provide name of the CPA firm \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Does an Independent Administrator service the Plan? ☐ YES ☐ NO

If yes, provide name of Administrator \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*Please note Independent Administrators will not be covered under Bond unless you contact your Branch Office.*

3. How many trustees are there for the Plan? \_\_\_\_\_

4. Are two signatures required to withdraw from the Plan? ☐ YES ☐ NO (If no, submit to your Branch Office for underwriting)

5. Who reconciles Plan's bank statement? \_\_\_\_\_

6. Who deposits funds in Plan's accounts? \_\_\_\_\_

*(If the same name is listed in both questions 5 and 6, submit application to your Branch Office for underwriting)*

Amount of Bond \$ \_\_\_\_\_

**Qualified Plan Assets \$** \_\_\_\_\_ *Bond amount must be for at least 10% of Qualified Plan Assets. Maximum Bond limit is \$500,000.*

**Non-Qualified Plan Assets \$** \_\_\_\_\_ *Bond amount must be for 100% of the Non-Qualified Plan Assets.*

Premium Basis ☐ 1 Year prepaid ☐ 3 Year Prepaid Proposed Effective Date \_\_\_\_\_

Is Inflation Guard Coverage desired? ☐ YES ☐ NO

Please call the Branch Office for Authorization on Bonds over \$100,000.

### READ CAREFULLY AND SIGN

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~~Signed at~~ \_\_\_\_\_

Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) ~~Trustee~~ (Title)

**~~SUBMITTING AGENT'S INFORMATION:~~**

~~Name:~~ \_\_\_\_\_ ~~License Number:~~ \_\_\_\_\_

~~Mailing Address:~~ \_\_\_\_\_

~~Phone:~~ \_\_\_\_\_ ~~Contact:~~ \_\_\_\_\_

~~Underwriting Service Office Address:~~

~~<Service Office Location>~~



**FRAUD STATEMENT:****APPLICABLE IN: AL, AR, DC, LA, MD, NM, RI AND WV**

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**APPLICABLE IN: FL AND OK**

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**APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN: KY, NY, OH AND PA**

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**APPLICABLE IN: ME, TN, VA AND WA**

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**APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICABLE IN: OR**

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**APPLICABLE IN: VT**

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Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

~~<Company Name>~~  
~~<Service Office Location>~~

## APPLICATION FOR FIDELITY/FORGERY COVERAGES COMPREHENSIVE UNDERWRITING & RATING SURVEY (RENEWAL)

### NAMED INSURED:

If ERISA Coverage is needed provide the plan name

### INSURED'S ADDRESS:

Are you a      Proprietorship    ☐      Partnership    ☐      Corporation    ☐

1. Type of Business: \_\_\_\_\_
2. Date Established: \_\_\_\_\_
3. What is the total number of Employees? \_\_\_\_\_ Total number of Officers? \_\_\_\_\_  
 How many employees regularly handle money, securities, or inventory? \_\_\_\_\_  
 How many locations? \_\_\_\_\_ List other locations on reverse side and advise operation.
4. Amount of EMPLOYEE DISHONESTY COVERAGE Desired? \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_
5. Amount of FORGERY COVERAGE Desired? \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_
6. Effective date of coverage requested, *if this application is approved?* \_\_\_\_\_
7. Coverage is Primary    ☐      Coverage is excess over company/policy # \_\_\_\_\_

### INTERNAL CONTROLS:

8. Is an audit performed each year ?      YES    ☐      NO    ☐  
 Prepared by      CPA    ☐      INHOUSE    ☐  
*If CPA prepared, Is it an*    Audit    ☐      Review    ☐      Compilation    ☐
9. Are bank accounts reconciled by someone not authorized to deposit or withdraw therefrom?  
                  YES    ☐      NO    ☐
10. How Often? \_\_\_\_\_
11. Will all checks issued by the Insured be countersigned?      YES    ☐      NO    ☐  
 If no, who signs (advise name and position) \_\_\_\_\_

### PRESENT COVERAGE:

12. List all fidelity, and forgery coverages now carried: Check if none    ☐  
                  Coverage                      Limit of Liability                      Name of Insurer                      Policy Number

### LOSS EXPERIENCE:

13. List all employee dishonesty losses in the last three (3) years, itemizing each loss separately:  
 Check if none    ☐  
                  Date of Loss                      Amount                      Description                      Precautions Taken to Prevent Repetition



Surety & Fidelity Bond Department, P.O. Box 5900, Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## APPLICATION FOR FIDELITY/FORGERY COVERAGES COMPREHENSIVE UNDERWRITING & RATING SURVEY (RENEWAL)

### NAMED INSURED:

If ERISA Coverage is needed provide the plan name

### INSURED'S ADDRESS:

Are you a **Proprietorship** ☐ **Partnership** ☐ **Corporation** ☐

1. Type of Business: \_\_\_\_\_
2. Date Established: \_\_\_\_\_
3. What is the total number of Employees? \_\_\_\_\_ Total number of Officers? \_\_\_\_\_  
How many employees regularly handle money, securities, or inventory? \_\_\_\_\_  
How many locations? \_\_\_\_\_ List other locations on reverse side and advise operation.
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9. Are bank accounts reconciled by someone not authorized to deposit or withdraw therefrom? YES ☐ NO ☐
10. How Often? \_\_\_\_\_
11. Will all checks issued by the Insured be countersigned? YES ☐ NO ☐  
If no, who signs (advise name and position) \_\_\_\_\_

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12. List all fidelity, and forgery coverages now carried: Check if none ☐  

<u>Coverage</u>	<u>Limit of Liability</u>	<u>Name of Insurer</u>	<u>Policy Number</u>
_____	_____	_____	_____
_____	_____	_____	_____

### LOSS EXPERIENCE:

13. List all employee dishonesty losses in the last three (3) years, itemizing each loss separately:

Check if none ☐

<u>Date of Loss</u>	<u>Amount</u>	<u>Description</u>	<u>Precautions Taken to Prevent Repetition</u>
_____	_____	_____	_____
_____	_____	_____	_____

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(Signature) ~~Trustee~~ ~~(Title)~~

**SUBMITTING AGENT'S INFORMATION**

~~Name:~~ \_\_\_\_\_ ~~License Number:~~ \_\_\_\_\_

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Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Title)

\_\_\_\_\_  
 (Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

~~<Company Name>~~  
~~<Service Office Location>~~

## ~~DISTRICT OF COLUMBIA~~ APPLICATION FOR A CRIME PROTECTION POLICY FOR MERCANTILE ENTITIES

Named Insured: \_\_\_\_\_  
 (Please list all insured's, including Employee Benefit Plans)

Principal Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Policy Coverage offered: Crime Protection Policy for Mercantile Entities, **Loss Sustained Form**

Primary, excess, contributing with: \_\_\_\_\_

### INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES

#### INSURING AGREEMENT

1. Employee Dishonesty
2. Forgery or Alteration
3. Inside the Premises
4. Outside the Premises
5. Computer Fraud
6. Money Orders and Counterfeit Paper Currency

#### Limit of Insurance

\$  
\$  
\$  
\$  
\$  
\$

#### Deductible Amount

\$  
\$  
\$  
\$  
\$  
\$

Insuring Agreements added by Endorsement:

7. Loss of Clients' Property (SE 00 48, FEN 004)
8. Funds Transfer Fraud (SE 00 41)

\$  
\$

\$  
\$

To become effective or to be continued as of 12:01 a.m. on \_\_\_\_\_ to 12:01 a.m. on \_\_\_\_\_  
**Premium is payable: Annually**

#### 1. DESCRIPTION OF YOUR ORGANIZATION

(a) Type of business (check appropriate box):

Proprietorship ☐ Partnership ☐ Corporation ☐ Other ☐ If other, explain \_\_\_\_\_

(b) Date your business was established: \_\_\_\_\_

(c) Classify your predominant activity: (Check box below)

☐ Manufacturer ☐ Processor ☐ Wholesaler ☐ Distributor ☐ Retailer ☐ Servicer ☐ Other

(d) Describe the products or services of your predominant business or activity: \_\_\_\_\_

(e) Has there been any change in ownership or management within the past three years? ☐ Yes ☐ No

If "Yes", explain \_\_\_\_\_

#### 2. RATING DATA FOR INSURING AGREEMENTS

##### Insuring Agreements 1, 2 and 5

Classification of Employees: #of Officers \_\_\_\_\_ # of Employees \_\_\_\_\_

##### Insuring Agreement 7

List the number of employees who handle, have custody of, maintain records of or have access to money, securities or other property owned by **your clients**. \_\_\_\_\_

##### Insuring Agreements 3 and 4

(a) Indicate the number of locations \_\_\_\_\_

(b) Indicate the number of outside messengers \_\_\_\_\_

(c) Do guards accompany each messenger?

Yes ☐ No ☐

(d) Are your premises secured by watchpersons?

Yes ☐ No ☐

(e) Are your premises secured by an alarm system?

Yes ☐ No ☐

Please provide details: \_\_\_\_\_

(f) Is a safe used at all locations?

Yes ☐ No ☐

Please provide details: \_\_\_\_\_

(g) What other measures have been taken to provide physical protection (private conveyance, messenger bags, safe alarms, Armored Car, etc.)? \_\_\_\_\_

## APPLICATION FOR A CRIME PROTECTION POLICY FOR MERCANTILE ENTITIES

Named Insured: \_\_\_\_\_  
(Please list all insured's, including Employee Benefit Plans)

Principal Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Policy Coverage offered: Crime Protection Policy for Mercantile Entities, **Loss Sustained Form**

Primary, excess, contributing with: \_\_\_\_\_

### INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES

INSURING AGREEMENT	<u>Limit of Insurance</u>	<u>Deductible Amount</u>
1. Employee Dishonesty	\$	\$
2. Forgery or Alteration	\$	\$
3. Inside the Premises	\$	\$
4. Outside the Premises	\$	\$
5. Computer Fraud	\$	\$
6. Money Orders and Counterfeit Paper Currency	\$	\$
Insuring Agreements added by Endorsement:		
7. Loss of Clients' Property (SE 00 48, FEN 004)	\$	\$
8. Funds Transfer Fraud (SE 00 41)	\$	\$
9. Fraudulently Induced Transfers (SE 01 67)	\$	\$
10. ERISA Dishonesty Coverage (SE 01 71)	\$	\$

To become effective or to be continued as of 12:01 a.m. on \_\_\_\_\_ to 12:01 a.m. on \_\_\_\_\_

**Premium is payable: Annually**

#### 1. DESCRIPTION OF YOUR ORGANIZATION

- (a) Type of business (check appropriate box):  
 Proprietorship ☐ Partnership ☐ Corporation ☐ Other ☐ If other, explain \_\_\_\_\_
- (b) Date your business was established: \_\_\_\_\_
- (c) Classify your predominant activity: (Check box below)  
☐ Manufacturer ☐ Processor ☐ Wholesaler ☐ Distributor ☐ Retailer ☐ Servicer ☐ Other
- (d) Describe the products or services of your predominant business or activity: \_\_\_\_\_
- (e) Has there been any change in ownership or management within the past three years? ☐ Yes ☐ No  
 If "Yes", explain \_\_\_\_\_

#### 2. RATING DATA FOR INSURING AGREEMENTS

##### Insuring Agreements 1, 2 and 5

Classification of Employees: #of Officers \_\_\_\_\_ # of Employees \_\_\_\_\_

##### Insuring Agreement 7

List the number of employees who handle, have custody of, maintain records of or have access to money, securities or other property owned by **your clients**. \_\_\_\_\_

##### Insuring Agreements 3 and 4

- (a) Indicate the number of locations \_\_\_\_\_
- (b) Indicate the number of outside messengers \_\_\_\_\_
- (c) Do guards accompany each messenger? Yes ☐ No ☐
- (d) Are your premises secured by watchpersons? Yes ☐ No ☐
- (e) Are your premises secured by an alarm system? Yes ☐ No ☐
- Please provide details: \_\_\_\_\_

**3. AUDIT PROCEDURES**

- (a) Is there an audit by a CPA, public accountant, independent of your organization? ☐ Yes ☐ No  
 If "Yes", how often (check the appropriate box): ☐ Quarterly ☐ Semi-Annually ☐ Annually
- (b) Name and address of person performing audit: \_\_\_\_\_
- (c) Are all locations audited? ☐ Yes ☐ No
- (d) Is the audit in compliance with generally accepted auditing standards and so certified? ☐ Yes ☐ No  
 If "No", indicate the scope of services (check the appropriate box): ☐ Review ☐ Compilation  
☐ Other, Explain \_\_\_\_\_
- (e) Is the report rendered directly to the Owner, Partners or Directors? ☐ Yes ☐ No
- (f) Date of completion of last audit of: Cash and Accounts \_\_\_\_\_ Inventory \_\_\_\_\_
- (g) Were any discrepancies or loose practices commented upon in the audit? ☐ Yes ☐ No  
 If "Yes", submit a copy of the auditor's comments.
- (h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a Certified Public Accountant or equivalent? ☐ Yes ☐ No  
 If "Yes", are the reports rendered directly to the Owner, Partners or Directors? ☐ Yes ☐ No

**\* If coverage desired is at \$250,000 please submit a copy of the annual financial report**

**4. INTERNAL CONTROLS**

- (a) Are bank accounts reconciled monthly? ☐ Yes ☐ No
- (b) Are bank accounts reconciled by someone not authorized to deposit or withdraw? ☐ Yes ☐ No  
 If "No", explain \_\_\_\_\_
- (c) Is countersignature of all checks required? ☐ Yes ☐ No  
 Above what amount? \$ \_\_\_\_\_
- (d) Do you have (use) funds transfer transactions (i.e. Wire Transfers, ACH, EFT, etc.)? ☐ Yes ☐ No  
 If "Yes", How often are funds transfer transactions reconciled? \_\_\_\_\_  
 Are they reconciled by someone not authorized to approve, initiate or handle them? ☐ Yes ☐ No
- (e) Does supporting documentation accompany all checks to be signed? ☐ Yes ☐ No  
 If "No", explain \_\_\_\_\_
- (f) Do you maintain a list of approved vendors? ☐ Yes ☐ No
- (g) Are securities subject to the joint control of two or more employees? ☐ Yes ☐ No
- (h) Are your employees required to take at least 1 or 2 consecutive weeks of vacation? ☐ Yes ☐ No
- (i) Explain screening procedures for new employees: \_\_\_\_\_

**5. PRIOR INSURANCE**

- (a) Has any similar insurance been declined or canceled during the past three years? ☐ ~~Yes~~ ☐ ~~No~~  
 If "Yes", explain \_\_\_\_\_
- (b) Prior insurance to be superseded \_\_\_\_\_ Check here if none ☐

Policy Number	Discovery or Loss Sustained	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company

**6. PRIOR LOSSES**

- (a) List below all losses sustained during the past three years that were caused by a loss that would have been covered by an Insuring Agreement you are now applying for. Please list all losses, whether reimbursed or not.

Check here if none ☐

Date of Loss	Type of loss	Amount Recovered From Insurance	Amount Recovered from Other than Insurance	Amount of Loss Pending	Location of Loss

**\* If more than 2 losses, please attach a separate sheet with full details as outlined above.**

**7. GENERAL INFORMATION**

Business Hours	Average # of Employees on Duty	Frequency of Deposits	Night Depository Used?	Annual Gross Sales or Receipts for Last fiscal year.	Other Information



- (f) Is a safe used at all locations? Yes ☐ No ☐  
Please provide details: \_\_\_\_\_
- (g) What other measures have been taken to provide physical protection (private conveyance, messenger bags, safe alarms, Armored Car, etc.)? \_\_\_\_\_

### 3. AUDIT PROCEDURES

- (a) Is there an audit by a CPA, public accountant, independent of your organization? ☐ Yes ☐ No  
If "Yes", how often (check the appropriate box): ☐ Quarterly ☐ Semi-Annually ☐ Annually
- (b) Name and address of person performing audit: \_\_\_\_\_
- (c) Are all locations audited? ☐ Yes ☐ No
- (d) Is the audit in compliance with generally accepted auditing standards and so certified? ☐ Yes ☐ No  
If "No", indicate the scope of services (check the appropriate box): ☐ Review ☐ Compilation  
☐ Other, Explain \_\_\_\_\_
- (e) Is the report rendered directly to the Owner, Partners or Directors? ☐ Yes ☐ No
- (f) Date of completion of last audit of: Cash and Accounts \_\_\_\_\_ Inventory \_\_\_\_\_
- (g) Were any discrepancies or loose practices commented upon in the audit? ☐ Yes ☐ No  
If "Yes", submit a copy of the auditor's comments.
- (h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a Certified Public Accountant or equivalent? ☐ Yes ☐ No  
If "Yes", are the reports rendered directly to the Owner, Partners or Directors? ☐ Yes ☐ No
- \* If coverage desired is at \$250,000 please submit a copy of the annual financial report**

### 4. INTERNAL CONTROLS

- (a) Are bank accounts reconciled monthly? ☐ Yes ☐ No
- (b) Are bank accounts reconciled by someone not authorized to deposit or withdraw? ☐ Yes ☐ No  
If "No", explain \_\_\_\_\_
- (c) Is countersignature of all checks required? ☐ Yes ☐ No  
Above what amount? \$ \_\_\_\_\_
- (d) Do you have (use) funds transfer transactions (i.e. Wire Transfers, ACH, EFT, etc.)? ☐ Yes ☐ No  
If "Yes", How often are funds transfer transactions reconciled? \_\_\_\_\_  
Are they reconciled by someone not authorized to approve, initiate or handle them? ☐ Yes ☐ No
- (e) Does supporting documentation accompany all checks to be signed? ☐ Yes ☐ No  
If "No", explain \_\_\_\_\_
- (f) Do you maintain a list of approved vendors? ☐ Yes ☐ No
- (g) Are securities subject to the joint control of two or more employees? ☐ Yes ☐ No
- (h) Are your employees required to take at least 1 or 2 consecutive weeks of vacation? ☐ Yes ☐ No
- (i) Explain screening procedures for new employees: \_\_\_\_\_

### 5. PRIOR INSURANCE

- (a) Has any similar insurance been declined or canceled during the past three years? **(MO applicants DO NOT answer this question)** ☐ Yes ☐ No  
If "Yes" explain: \_\_\_\_\_
- (b) Prior insurance to be superseded Check here if none ☐

Policy Number	Discovery or Loss Sustained	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company

### 6. PRIOR LOSSES

- (a) List below all losses sustained during the past three years that were caused by a loss that would have been covered by an Insuring Agreement you are now applying for. Please list all losses, whether reimbursed or not.

Check here if none ☐

Date of Loss	Type of loss	Amount Recovered From Insurance	Amount Recovered from Other than Insurance	Amount of Loss Pending	Location of Loss

**\* If more than 2 losses, please attach a separate sheet with full details as outlined above.**

**8. COVERAGE AMENDMENTS****(a) Insuring Agreement 1**

If insurance is desired on any of your appointed **Agents**, whether they be persons, partnerships or corporations performing any act or service in connection with the ordinary conduct of your business, complete the following:

Names, Addresses of each Agent:Type of Service  
provided:Limit of Insurance

\_\_\_\_\_

\$ \_\_\_\_\_  
\$ \_\_\_\_\_**(b) Insuring Agreement 2**

If insurance is desired, complete the following:

No. of Cardholders:

Limit of Insurance:

**(1) Credit, Debit or Charge Card Instruments:**

Covered Instruments (check the appropriate box):

include ☐ or are limited to ☐ Credit, debit or charge cards

Issued to you or any employee for business purposes

\_\_\_\_\_ \$ \_\_\_\_\_

**(2) Personal Accounts of your officers or partners:**Name(s)\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_**(c) Insuring Agreements 3 and 4**

Increased or Reduced Limits

Limit of InsuranceSpecified Period**(a) If an increased limit is desired for a specified period, indicate:**Insuring Agreement 3 (*Inside the Premises*)

\$ \_\_\_\_\_

Insuring Agreement 4 (*Outside the Premises*)

\$ \_\_\_\_\_

**(b) If a decreased limit is desired while the business is closed and a custodian is not on duty, indicate Overnight Limit**

\$ \_\_\_\_\_

**(c) If a reduced limit is desired for designated premises, messengers or armored motor vehicle companies, complete the following:**

Address of Premises	Names of Messengers	Names of Armored Motor Vehicle Companies	Limit of Insurance
_____	_____	_____	_____
_____	_____	_____	_____

**READ CAREFULLY AND SIGN**

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

**~~FRAUD STATEMENT~~**

~~ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.~~

Signed at: \_\_\_\_\_ Insured \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_ By: \_\_\_\_\_

~~(Signature) Officer or Director (Title)~~**~~SUBMITTING AGENCY'S INFORMATION~~**

Contact Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**7. GENERAL INFORMATION**

Business Hours	Average # of Employees on Duty	Frequency of Deposits	Night Depository Used?	Annual Gross Sales or Receipts for Last fiscal year.	Other Information

**8. COVERAGE AMENDMENTS****(a) Insuring Agreement 1**

If insurance is desired on any of your appointed **Agents**, whether they be persons, partnerships or corporations performing any act or service in connection with the ordinary conduct of your business, complete the following:

Names, Addresses of each Agent:

Type of Service provided:

Limit of Insurance

\_\_\_\_\_

\$ \_\_\_\_\_  
\$ \_\_\_\_\_

**(b) Insuring Agreement 2**

If insurance is desired, complete the following:

No. of Cardholders:

Limit of Insurance:

**(1) Credit, Debit or Charge Card Instruments:**

Covered Instruments (check the appropriate box):

include ☐ or are limited to ☐ Credit, debit or charge cards

Issued to you or any employee for business purposes

**(2) Personal Accounts of your officers or partners:**

Name(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_

**(c) Insuring Agreements 3 and 4**

Increased or Reduced Limits

Limit of Insurance

Specified Period

**(a) If an increased limit is desired for a specified period, indicate:**

Insuring Agreement 3 (*Inside the Premises*)

\$ \_\_\_\_\_

Insuring Agreement 4 (*Outside the Premises*)

\$ \_\_\_\_\_

**(b) If a decreased limit is desired while the business is closed and a custodian is not on duty, indicate Overnight Limit**

\$ \_\_\_\_\_

**(c) If a reduced limit is desired for designated premises, messengers or armored motor vehicle companies, complete the following:**

Address of Premises	Names of Messengers	Names of Armored Motor Vehicle Companies	Limit of Insurance

**READ CAREFULLY AND SIGN**

The employees of the Insured have all, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information, which in the judgment of the Insured indicates that any of the said employees are dishonest. Such knowledge as any officer signing for the Insured may now have in respect to his own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.



**FRAUD STATEMENT:****APPLICABLE IN: AL, AR, DC, LA, MD, NM, RI AND WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. \*Applies in MD only.

**APPLICABLE IN: CO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**APPLICABLE IN: FL AND OK**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.

**APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY only.

**APPLICABLE IN: ME, TN, VA AND WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME only.

**APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICABLE IN: OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)

\_\_\_\_\_  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_



## APPLICATION FOR A CRIME PROTECTION POLICY FOR PUBLIC ENTITIES

**Named Insured:** \_\_\_\_\_

**Principal Address:** \_\_\_\_\_

Policy Coverage offered: Crime Protection Policy for Public Entities, **Loss Sustained form**

This policy will be Primary ☐ Excess ☐ If EXCESS, enter Primary Policy # and carrier: \_\_\_\_\_

### INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES

#### INSURING AGREEMENTS

#### Limit of Insurance

#### Deductible Amount

- |  |    |    |
|--|----|----|
| 1. Employee Dishonesty                         | \$ | \$ |
| Per Employee (Up to \$25,000)                  | \$ | \$ |
| 2. Forgery or Alteration                       | \$ | \$ |
| 3. Inside the Premises                         | \$ | \$ |
| 4. Outside the Premises                        | \$ | \$ |
| 5. Computer Fraud                              | \$ | \$ |
| 6. Money Orders and Counterfeit Paper Currency | \$ | \$ |

Insuring Agreements added by Endorsement

- |                                    |               |               |
|------------------------------------|---------------|---------------|
| 7. Loss of Clients' Property       | \$            | \$            |
| <del>8. Funds Transfer Fraud</del> | <del>\$</del> | <del>\$</del> |

~~to become effective or to be continued as of 12:01 a.m. on \_\_\_\_\_ to 12:01 a.m. on \_\_\_\_\_~~

**Premium is payable: Annually**

If this insurance indemnifies an Obligor other than the Named Insured, list below the Obligor name and address:

\_\_\_\_\_

#### 1. DESCRIPTION OF YOUR ORGANIZATION:

- (a) Is your organization a part of the government of the (check the appropriate box): State ☐, County ☐, City ☐, Town ☐  
Township ☐, Village ☐, Borough ☐, Other Political Subdivision ☐ \_\_\_\_\_
- (b) Is insurance being provided for a School System? ~~Yes~~ ☐ No ☐

#### 2. RATING DATA FOR COVERAGE FORMS 1, 2, 5 AND 7

**Note: Persons required by law to be individually bonded and treasurers or tax collectors by whatever title known, are excluded from coverage under Insuring Agreement 1.**

- (a) Classification of Employees: Enter the number total number of all your employees (excluding those that are required by law to be individually bonded): \_\_\_\_\_
- (b) If Faithful Performance of Duty Coverage is desired, enter the number of your Patrolmen/Women: \_\_\_\_\_
- (c) If Agreement 7 is desired, please provide the number of employees who handle, have custody of, maintain records of, or have access to, money, securities or other property owned by your clients. \_\_\_\_\_

#### 3. RATING DATA FOR INSURING AGREEMENTS 3 AND 4

- (a) Indicate the number of locations \_\_\_\_\_
- (b) Indicate the number of outside messengers \_\_\_\_\_
- (c) Do guards accompany each messenger? Yes ☐ No ☐
- (d) Are your premises secured by watchpersons? Yes ☐ No ☐
- (e) Are your premises secured by an alarm system? Yes ☐ No ☐ If Yes, provide details \_\_\_\_\_
- (f) Is a safe used at all locations? Yes ☐ No ☐ If yes, provide details \_\_\_\_\_
- (g) What other measures have been taken to provide physical protection (private conveyance, messenger bags, safe alarms, etc.)? \_\_\_\_\_



Surety & Fidelity Bond Department, P.O. Box 5900, Madison, WI 53701

Capitol Indemnity Corporation  
Platte River Insurance Company

## APPLICATION FOR A CRIME PROTECTION POLICY FOR PUBLIC ENTITIES

Named Insured: \_\_\_\_\_

Principal Address: \_\_\_\_\_

Policy Coverage offered: Crime Protection Policy for Public Entities, **Loss Sustained form**

This policy will be Primary ☐ Excess ☐ If EXCESS, enter Primary Policy # and carrier:

### INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES

#### INSURING AGREEMENTS

	<u>Limit of Insurance</u>	<u>Deductible Amount</u>
1. Employee Dishonesty	\$	\$
Per Employee (Up to \$25,000)	\$	\$
2. Forgery or Alteration	\$	\$
3. Inside the Premises	\$	\$
4. Outside the Premises	\$	\$
5. Computer Fraud	\$	\$
6. Money Orders and Counterfeit Paper Currency	\$	\$
Insuring Agreements added by Endorsement		
7. Loss of Clients' Property ( <u>SE 00 48 FEN 004</u> )	\$	\$
8. Funds Transfer Fraud ( <u>SE 00 41</u> )	\$	\$
9. Fraudulently Induced Transfers ( <u>SE 01 67</u> )	\$	\$
10. ERISA Dishonesty Coverage ( <u>SE 01 71</u> )	\$	\$

To become effective or to be continued as of 12:01 a.m. on \_\_\_\_\_ to 12:01 a.m. on \_\_\_\_\_

**Premium is payable: Annually**

If this insurance indemnifies an Obligor other than the Named Insured, list below the Obligor name and address:

#### 1. DESCRIPTION OF YOUR ORGANIZATION:

- (a) Is your organization a part of the government of the (check the appropriate box): State ☐, County ☐, City ☐, Town ☐  
Township ☐, Village ☐, Borough ☐, Other Political Subdivision ☐ \_\_\_\_\_
- (b) Is insurance being provided for a School System? \_\_\_\_\_ Yes ☐ No ☐

#### 2. RATING DATA FOR COVERAGE FORMS 1, 2, 5 AND 7

**Note: Persons required by law to be individually bonded and treasurers or tax collectors by whatever title known, are excluded from coverage under Insuring Agreement 1.**

- (a) Classification of Employees: Enter the number total number of all your employees (excluding those that are required by law to be individually bonded): \_\_\_\_\_
- (b) If Faithful Performance of Duty Coverage is desired, enter the number of your Patrolmen/Women: \_\_\_\_\_
- (c) If Agreement 7 is desired, please provide the number of employees who handle, have custody of, maintain records of, or have access to, money, securities or other property owned by your clients. \_\_\_\_\_

#### 3. RATING DATA FOR INSURING AGREEMENTS 3 AND 4

- (a) Indicate the number of locations \_\_\_\_\_
- (b) Indicate the number of outside messengers \_\_\_\_\_
- (c) Do guards accompany each messenger? Yes ☐ No ☐
- (d) Are your premises secured by watchpersons? Yes ☐ No ☐
- (e) Are your premises secured by an alarm system? Yes ☐ No ☐ If Yes, provide details \_\_\_\_\_
- (f) Is a safe used at all locations? Yes ☐ No ☐ If yes, provide details \_\_\_\_\_
- (g) What other measures have been taken to provide physical protection (private conveyance, messenger bags, safe alarms, etc.)? \_\_\_\_\_

**4. AUDIT PROCEDURES:**

- (a) Is there an audit by a CPA, public accountant or equivalent, independent of your organization?

Yes ☐ No ☐If "Yes," how often (check the appropriate box): ~~Quarterly~~ ☐; Semi-Annually ☐, Annually ☐

- (b) Name and Address of person or firm performing audit \_\_\_\_\_

- (c) Are all locations audited? \_\_\_\_\_ Yes
- ☐
- No
- ☐

- (d) Is the audit made in accordance with generally accepted auditing standards and so certified? Yes
- ☐
- No
- ☐

If "No," explain the scope of the audit \_\_\_\_\_

- (e) Is the audit report rendered to a regulatory authority? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "Yes," to whom are the reports rendered? \_\_\_\_\_

- (f) Date of completion of last audit \_\_\_\_\_

- (g) Were any discrepancies or internal control weaknesses commented upon in the audit? ..... Yes
- ☐
- No
- ☐

If "Yes," submit a copy of the audit and auditor's comments.

- (h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a public accountant or equivalent? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "Yes," to whom are the reports rendered? \_\_\_\_\_

**5. INTERNAL CONTROLS (OTHER THAN AUDIT PROCEDURES):**

- (a) Are bank accounts reconciled monthly? \_\_\_\_\_ Yes
- ☐
- No
- ☐

- (b) Are bank accounts reconciled by someone not authorized to deposit or withdraw? ..... Yes
- ☐
- No
- ☐

If "No," explain: \_\_\_\_\_

- (c) Is countersignature of checks required? ..... Yes
- ☐
- No
- ☐

If "No," explain: \_\_\_\_\_

- (d) Does supporting documentation accompany all checks to be signed? ..... Yes
- ☐
- No
- ☐

If "No," explain: \_\_\_\_\_

- (e) Are securities subject to joint control of two or more responsible employees? ..... Yes
- ☐
- No
- ☐

If "No," explain: \_\_\_\_\_

- (f) Explain your screening procedures for new employees \_\_\_\_\_

**6. PRIOR INSURANCE:**

- (a) Has any similar insurance been declined or cancelled during the past three years? ..... Yes
- ☐
- No
- ☐

If "Yes," explain \_\_\_\_\_

- (b) Prior insurance to be superseded ..... Check if none
- ☐

Policy Number	Policy form was: Discovery? Loss Sustained?	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company
				\$	

**7. PRIOR LOSSES:**

- (a) List below all losses sustained during the past three years that were caused by: employee dishonesty, forgery, theft of money or securities on or off the premises, computer fraud or counterfeit currency. Please list all losses, whether reimbursed or not. \_\_\_\_\_ Check if none
- ☐

Date of Loss	Type of Loss	Amount of Loss	Amount Recovered from Insurance	Amount Recovered from other than Insurance	Amount of Loss Pending
		\$	\$	\$	\$
		\$	\$	\$	\$

NOTE: If more than 2 losses, please attach a separate sheet describing the loss details.



**4. AUDIT PROCEDURES:**

- (a) Is there an audit by a CPA, public accountant or equivalent, independent of your organization?

Yes ☐ No ☐If "Yes," how often (check the appropriate box): Quarterly ☐, Semi-Annually ☐, Annually ☐

- (b) Name and Address of person or firm performing audit \_\_\_\_\_

- (c) Are all locations audited? \_\_\_\_\_ Yes
- ☐
- No
- ☐

- (d) Is the audit made in accordance with generally accepted auditing standards and so certified? Yes
- ☐
- No
- ☐

If "No," explain the scope of the audit \_\_\_\_\_

- (e) Is the audit report rendered to a regulatory authority? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "Yes," to whom are the reports rendered? \_\_\_\_\_

- (f) Date of completion of last audit \_\_\_\_\_

- (g) Were any discrepancies or internal control weaknesses commented upon in the audit? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "Yes," submit a copy of the audit and auditor's comments.

- (h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a public accountant or equivalent? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "Yes," to whom are the reports rendered? \_\_\_\_\_

**5. INTERNAL CONTROLS (OTHER THAN AUDIT PROCEDURES):**

- (a) Are bank accounts reconciled monthly? \_\_\_\_\_ Yes
- ☐
- No
- ☐

- (b) Are bank accounts reconciled by someone not authorized to deposit or withdraw? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "No," explain: \_\_\_\_\_

- (c) Is countersignature of checks required? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "No," explain: \_\_\_\_\_

- (d) Does supporting documentation accompany all checks to be signed? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "No," explain: \_\_\_\_\_

- (e) Are securities subject to joint control of two or more responsible employees? \_\_\_\_\_ Yes
- ☐
- No
- ☐

If "No," explain: \_\_\_\_\_

- (f) Explain your screening procedures for new employees \_\_\_\_\_

**6. PRIOR INSURANCE:**

- (a) Has any similar insurance been declined or cancelled during the past three years?
- (MO applicants DO NOT answer this question)**
- Yes
- ☐
- No
- ☐

If "Yes," explain \_\_\_\_\_

- (b) Prior insurance to be superseded \_\_\_\_\_ Check if none
- ☐

Policy Number	Policy form was: Discovery? Loss Sustained?	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company
				\$	

**7. PRIOR LOSSES:**

- (a) List below all losses sustained during the past three years that were caused by: employee dishonesty, forgery, theft of money or securities on or off the premises, computer fraud or counterfeit currency. Please list all losses, whether reimbursed or not.

Check if none ☐

Date of Loss	Type of Loss	Amount of Loss	Amount Recovered from Insurance	Amount Recovered from other than Insurance	Amount of Loss Pending
		\$	\$	\$	\$
		\$	\$	\$	\$

NOTE: If more than 2 losses, please attach a separate sheet describing the loss details.



**8. COVERAGE AMENDMENTS (ENDORSEMENTS)****INSURING AGREEMENT 1**

## (a) Agents Coverage:

If insurance is desired on any of your appointed or elected **Agents**, whether they are persons, partnerships or corporations while performing any act or service in connection with the ordinary function of your organization, complete the following:

<u>Capacity in Which Each Agent Serves:</u>	<u>Limit of Insurance</u>
_____	\$ _____
_____	\$ _____

**\* If more than two agents, attach a separate sheet to provide the details.**

**INSURING AGREEMENT 3 and 4:**

## (a) Peak Season:

1) If an increased limit is desired for a specified period, indicate:

	<u>Increased Limit</u>	<u>Specified Period (mm/dd/yy)</u>	
	<u>Of Insurance</u>	<u>Start Date:</u>	<u>End Date:</u>
Insuring Agreement 3	\$ _____	_____	_____
Insuring Agreement 4	\$ _____	_____	_____

2) If a decreased limit is desired while the business is closed and a custodian is not on duty, indicate: \$ \_\_\_\_\_

## (b) Schedule Coverage

If schedule coverage is desired, complete the following: **(or attach a sheet to list more locations):**

Address of Premises	Insuring Agreement 3 Limit of Insurance	Insuring Agreement 4 Limit of Insurance	Number of Armored Motor Vehicles	Number of Messengers

The present officials/officers and employees of the Insured, in the positions held, as shown herein, have, to the best of the Insured's knowledge and belief, while in the service of the Insured always performed their respective duties honestly. There has never come to its notice or knowledge any information which in the judgment of the Insured indicated that any of the said officials/officers or employees are dishonest. Such knowledge that any official or officer signing for the Insured may now have in respect to his or her own personal acts or conduct, unknown to the Insured, is not imputable to the Insured.

**FRAUD STATEMENT:****APPLICABLE IN: AL, AR, DC, IL, IA, MD, NM, RI AND WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

\*Applies in MD only.

**APPLICABLE IN: CO**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**APPLICABLE IN: FL AND OK**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL only.



**APPLICABLE IN: KS**

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**APPLICABLE IN: KY, NY, OH AND PA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)\* \*Applies in NY only.

**APPLICABLE IN: ME, TN, VA AND WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME only.

**APPLICABLE IN: NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**APPLICABLE IN: OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**APPLICABLE IN: VT**

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: \_\_\_\_\_ Insured: \_\_\_\_\_

This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_ By: \_\_\_\_\_  
(Signature) (Title)  
(Print Name)

**SUBMITTING AGENCY'S INFORMATION**

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_